Waiver of Group Health Plan Coverage

Company Name **ACT-1 Group / AppleOne**	Jobsite Location	Date of Hire
Employee Name (Last, First, M.I.)	Social Security Number	Date of Birth
Home address		
City	State	Zip code

As a Full Time employee of **ACT-1 Group / AppleOne**, you are automatically enrolled in "Employee Only" coverage under the *Aetna MedPremier Major Medical Health Plan***.** If you are currently covered under another Employer-Sponsored Major Medical Group Health Plan and wish to waive your coverage as an employee of **ACT-1 Group / AppleOne**, **you must submit this completed Benefit Election Waiver and proof of other coverage within the Open Enrollment window of 11/14/16 – 11/28/16**.

The following coverage types **do not** qualify to waive **ACT-1 Group / AppleOne** *Aetna MedPremier Major Medical Health Plan* coverage: Tricare; Medicare; Medicaid; Veterans Administration (VA); Indian Health Services (IHS); individual plans (non-Employer Sponsored plans), including individual Qualified Health Plans purchased through a state or federal Affordable Care Act Exchange or Marketplace. **For more information, refer to 32 C.F.R. §199 and 42 U.S.C. §1395y(b)(3).**

Proof of other coverage is required. Please make a copy of the front and back of your current insurance identification card and attach the copy to this form for verification purposes. Your name must be visible on the card. If your name is not visible on the card, provide a letter, on the company's letterhead, from the insurance provider confirming that you are covered by the plan.

To waive coverage, initial **all** of the following statements:

- For the plan year effective ____/____/_____, I am waiving coverage under the **ACT-1 Group / AppleOne** *Aetna MedPremier Major Medical Health Plan*, because I have **active** coverage under another Employer-Sponsored Major Medical Group Health Plan. *Initial:* _____
- I understand that if I do not submit the completed Benefit Election Waiver and the required supporting documentation within the timeframe indicated above, I will not be allowed to waive coverage, and I will not be given another opportunity to waive this plan until a subsequent open enrollment period or until I experience a qualifying life event (QLE). *Initial:* _____
- I understand that choosing to waive employer-sponsored group health plan coverage may lead to disqualification for, loss of, or repayment of any tax credits or subsidies used to purchase an individual Qualified Health Plan through a state or federal Exchange/Marketplace. *Initial:* _____
- I understand that by choosing not to participate in the *Aetna MedPremier Major Medical Health Plan*, I am waiving coverage under the plan available to me through **ACT-1 Group / AppleOne.** I understand that in order to waive coverage, my supporting documentation, for active Group Health coverage, must fulfill the requirements stated above. I also understand that I am making a binding election with respect to my benefits and that I will not have an opportunity to enroll in the plan unless I experience a qualifying life event. *Initial:* _____
- **I have** read or had read to me the completed waiver form. **I represent** that all statements and answers made on or attached to this waiver form are true to the best of my knowledge and belief. *Initial:* _____

Signature of Employee **Date of Signature**

Mail form to: The Boon Group, Attn: Govt. Enrollment, 6300 Bridgepoint Pkwy, Bldg. 3, Suite 500, Austin, TX 78730
Or **Fax** form to: (512) 339-6662 Attn: Government Enrollment