WAIVER OF COVERAGE FORM

You may decline health coverage offered by Trenholm State Community College. This is called a waiver of coverage. If you waive coverage for yourself, you may not cover dependents under the College's health plan.

If you decline coverage considered affordable and minimum essential under the Patient Protection and Affordable Care Act ("ACA"), you will not qualify for government credits and subsidies to purchase individual health insurance on the Marketplace.

The decision to waive coverage has consequences for you. For example:

1. You should be aware of the individual responsibility requirement that is in effect under the ACA. If you refuse the offer of the College's health coverage and do not obtain coverage on your own, you will be subject to a penalty.

2. Unless you sign a waiver stating that you are covered under another plan, such as a spouse's plan, Medicaid, Medicare, the Retirement Systems of Alabama (as retiree), or other plan, you cannot enroll in the College's health plan until the next open enrollment. However, if you are covered under another plan, but that coverage is lost, you can enroll in your College's health plan immediately. There is a time limit for enrolling after the other coverage is lost. You must request to enroll in your plan within 30 days of losing the other coverage.

3. If you gain a new dependent through birth, adoption or marriage, you may enroll yourself, the new dependent, and the entire family at that time, but you must do so within 30 days of gaining the new dependent. If you miss the 30-day enrollment deadline, you must wait until open enrollment.

EMPLOYEE'S ACKNOWLEDGEMENTS AND WAIVER

I acknowledge that the College has offered me affordable minimum essential coverage, as defined under the ACA, for the period from __________ to __________.

I voluntarily waive this coverage and state that I am covered under another plan.

I have read the above and I understand the consequences of my waiver of coverage.

________________________________________
Name of Employee

________________________________________
Employee Signature

________________________________________
Date

Revised 4/3/2020