

Hamilton College Medical Plan Waiver Form

About this form: With this form, you can waive your medical plan coverage.

PLEASE PRINT

SECTION A – PERSONAL INFORMATION							
Employee Name (last name, first name)	Social Security Number						
Effective Date	Marital Status						
1/1/2019	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner						
SECTION B – MEDICAL WAIVER							
<p><input type="checkbox"/> I am electing NO medical coverage. <i>Benefits from this election will be added to my taxable income.</i></p> <p>You must check one box below to indicate your reason.</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; padding: 10px;"><input type="checkbox"/> I have medical insurance through my spouse/domestic partner’s employer</td> <td style="width: 50%; padding: 10px;"><input type="checkbox"/> I have medical insurance through Medicare or Medicaid</td> </tr> <tr> <td style="padding: 10px;"><input type="checkbox"/> I am covered under a stand-alone medical policy (not through a group)</td> <td style="padding: 10px;"><input type="checkbox"/> I do not wish to have any medical coverage. I understand I will not receive the College’s waiver payment if I do not have other coverage.</td> </tr> <tr> <td style="padding: 10px;"><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>		<input type="checkbox"/> I have medical insurance through my spouse/domestic partner’s employer	<input type="checkbox"/> I have medical insurance through Medicare or Medicaid	<input type="checkbox"/> I am covered under a stand-alone medical policy (not through a group)	<input type="checkbox"/> I do not wish to have any medical coverage. I understand I will not receive the College’s waiver payment if I do not have other coverage.	<input type="checkbox"/> Other _____	
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<input type="checkbox"/> Other _____							
<p><i>I understand that I must report any change in family status that may impact my medical plan coverage to Human Resources within 30 days of the event.</i></p> <p><i>I further understand that the medical coverage that I am waiving is minimum essential coverage that is considered affordable and meets the minimum value requirements of the Affordable Care Act. I understand that as a result of this coverage offer by the College, I may not be eligible for a premium tax credit if I obtain coverage through an Exchange (Marketplace) plan.</i></p> <p><i>I certify that the information provided on this Medical Plan Waiver Form is true and correct and will be relied upon by the College.</i></p> <p><i>Sign here if you are declining medical coverage.</i></p>							
_____ Employee Signature	_____ Date						