Professional Benefit Administrators, Inc.

Annual Request for Waiver of Group Coverage

Employer: The City of Lake Forest **Group#:** 010102

Employee: _____ **IID#:** _____

I hereby certify that I have been offered an opportunity to become covered under the group plan of my employer. I have decided not to take advantage of this offer.

I Decline the following coverages (check all boxes that apply):

☐ Medical for myself and/or dependents

☐ Medical for my dependents only

☐ Dental (if applicable) for myself and/or dependents

☐ Dental (if applicable) for my dependents only

☐ Vision (if applicable) for myself and/or dependents

☐ Vision (if applicable) for my dependents only

☐ Other (explain): _____

This election to decline coverage is for the following reasons (select one):

☐ Spouse has coverage for me and/or my dependents

☐ I have individual (not group) coverage for myself and/or my dependents

☐ I do not wish to pay for coverage for me and/or my dependents and do not have other group or individual coverage.

☐ Other (explain): _____

I understand that if I waive coverage for myself and/or my eligible dependents (including my spouse), I will not be able to enroll at a later date unless I qualify for a special enrollment event outlined in the HIPAA or other applicable law, example: (a) I am waiving coverage because I am covered under my spouses group health plan and they lose the coverage involuntarily, or my spouses Employer stops contributing towards my or my dependents' other coverage, (b) I get married, (c) I have a child, adopt a child or have a child placed with me for adoption (d) My eligible child loses coverage under a state sponsored plan or becomes eligible for a premium assistance subsidy under a state sponsored plan. For events (a), (b) and (c) I understand I have 30 days to enroll from the event date for event (d) I understand I have 60 days to enroll. (OR) If I apply for coverage during the open enrollment period designated by my employer, I will not be covered until the effective date outlined on the Schedule of Benefits in the Summary Plan Description, following the completion of an enrollment form.

The Affordable Care Act requires that you, and each member of your family, have health care coverage. If you do not have coverage for each month of the taxable year you will pay a penalty when you file your Federal Income Tax Return. Please visit ***www.irs.gov/Affordable-Care-Act/Individuals-and-Families*** for more information.

I declare that I have read and understand the limitations on enrolling at a later date. I also declare that the information given on this Waiver is correctly recorded and true. To request special enrollment or obtain more information, contact your Human Resource Department.

Print Name: _____

Signature: _____ Date: _____