Spooner Area School District

801 County Highway A · Spooner, WI 54801 · 715-635-2171 · www.spooner.k12.wi.us

Waiver and Attestation Form: Health Insurance

Employee Name _____ Employee ID or SSN _____

Address _____ City _____ State_____ Zip _____

Please read each of the following and initial each box:

☐ I certify that I and any eligible dependents were offered the opportunity to enroll in an employer provided group health insurance program that offered minimum essential coverage (MEC), was "affordable" (according to one of the 3 IRS provided safe harbors available under the ACA) and offered minimum value (MV).

☐ I have elected to waive the opportunity to enroll in this coverage at open enrollment knowing that the next opportunity to enroll will not be until 12 months from now, unless I experience a qualifying event which must be reported within 30 days.

☐ I exercise my right to receive monthly payments rather than receive any benefits or coverage under the employer provided group health insurance program.

☐ I and any eligible dependents are enrolled in health insurance coverage that provides minimum essential coverage (MEC) through (please check the appropriate box):

A spouse's employer plan ☐

Medicare ☐

Medicaid ☐

Champus/TriCare ☐

☐ In order for me to continue to qualify for this cash option, I must annually re-enroll by submitting this attestation form. My failure to do so will result in automatic ineligibility and the cash payment will be terminated for the next calendar year.

I agree to all the terms and conditions of this program and the terms and conditions are fully understood. I certify the information furnished is true and accurate. False statements on this form may subject me to disciplinary action, up to and including discharge.

_____
Employee Name (Print)

_____ _____
Employee Signature Date

_____ _____
Witness Date