Heluna Health
EMPOWERING POPULATION HEALTH INITIATIVES SINCE 1969

Group Medical Plan Waiver Form
Plan Year: August 1, 2024 – July 31, 2025

Employee Name:

Employee ID Number:

MEDICAL PLANS ONLY

SECTION A (check the applicable option below if you are waiving medical plan coverage due to being enrolled in one of the following plans):

- ☐ Employer-sponsored group health plan with minimum essential coverage under my spouse's/domestic partner's plan
- ☐ Employer-sponsored group health plan with minimum essential coverage under my parent's plan
- ☐ School Health Plan
- ☐ Medicare
- ☐ VA
- ☐ TRICARE
- ☐ Medicaid/Medi-Cal
- ☐ Other _____

SECTION B (check the applicable plan option you are enrolled in and choose to keep your policy while waiving Heluna Health's affordable health plan):

Important notice: Heluna Health offers at least 1 health plan considered affordable by Affordable Care Act (ACA). You are NOT eligible for medical plan subsidy through one of the ACA exchanges. You may be subject to tax penalties or may be required to pay back any premium assistance received while being eligible for Heluna Health's affordable coverage.

- ☐ Healthcare Exchange policy
- ☐ Individual (Off Exchange) policy

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SECTION C (ACA waiver acknowledgement):

By signing below, I certify that I have been given an opportunity to apply for ACA qualified medical plan coverage for myself and all my eligible tax dependents (if any) including spouse or qualified domestic partner. I am declining enrollment in any of the medical plan options offered by Heluna Health. I understand that, if I am declining enrollment for myself or any of my eligible tax dependents (including my spouse or qualified domestic partner) because of current enrollment in other health plan with minimum essential coverage or group health plan with minimum essential coverage, I may be able to enroll myself and my eligible tax dependents in this plan if I lose, or my eligible tax dependents lose, eligibility for that other coverage (or if the employer stops contributing towards me or my eligible tax dependents' other coverage).

I understand that I must request enrollment no more than 30 days after the date the other health plan coverage ends (or after the employer stops contributing toward the other coverage). If I do not do so, I will not be able to enroll until my employer's next annual open enrollment period.

In addition, I understand that if I have a newly eligible tax dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my eligible dependent(s). However, I must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. I understand that in order to request special enrollment or obtain more information, I should contact my Employee Benefits Administrator by phone at (562) 205-2433 or by email at benefits@helunahealth.org.

Employee Signature	Date