Bellmore-Merrick CHSD
Office of Personnel & Administration

AFFORDABLE CARE ACT (ACA) WAIVER

Employee Name: _____

Date: _____

Plan Year: **2019**

Please Check ONE:	
☐	I waive enrollment in my employer's NYSHIP/EMPIRE, HIP Prime HMO I, and HIP Prime HMO II group health insurance plans for myself **(INDIVIDUAL).**
☐	I waive enrollment in my employer's NYSHIP/EMPIRE, HIP Prime HMO I, and HIP Prime HMO II group health insurance plans for myself AND my dependents **(FAMILY).**
☐	I am enrolling/enrolled in my employer's (circle one: NYSHIP/EMPIRE, HIP Prime HMO I, HIP Prime HMO II) group health insurance plan for myself but I am waiving coverage for my dependents **(ENROLLING/ENROLLED IN INDIVIDUAL, OPTING OUT OF FAMILY FOR DEPENDENTS).**

Reason for Waiving- Please check ONE:	
☐	I am covered through my spouse's employer OR
☐	I am covered through my former employer's retiree health insurance plan OR
☐	I am covered through a parent's employer OR
☐	Other. Please Explain:_____

I understand that I am waiving coverage in my employer's* NYSHIP/EMPIRE, HIP Prime HMO I, and HIP Prime HMO II *group health insurance plans as noted above.

Employee Signature: _____ Date: _____

Personnel Signature: _____ Date: _____