2024 Benefit Election Medical Waiver Form

_____
Print Name

Initial below:

_____I acknowledge that the American Library Association (ALA) has offered me medical coverage that, according to Patient Protection and Affordable Care Act ("ACA") is considered affordable minimum essential coverage.

_____I have decided not to take advantage of this offer.

I am waiving coverage because:

_____ I am covered under another plan _____

I understand that if I lose coverage under this other plan, I can enroll in the ALA plan if I provided written notice that the coverage is ending within 30 days of losing the other coverage otherwise I will have to wait for open enrollment.

_____ I am waiving coverage because _____

_____I understand that if I have a life change event such as gain or lose a new dependent through marriage, divorce, birth, or adoption I may make a change consistent with the life event within 30 days. If I miss the 30-day enrollment deadline, I realize open enrollment will be the next time I can make any changes.

_____ I understand that if I decline coverage offered from an employer that is considered affordable and minimum essential under the ACA, I will not qualify for government credits and subsidies to purchase individual health insurance on the Marketplace.

_____I understand that, in compliance with the ACA, I have an individual responsibility and if I refuse health coverage from an employer and I do not obtain coverage on my own, I will be subject to a penalty.

_____ I have read the above and I understand the consequences of my waiver of coverage.

_____ _____
Print Name Signature

_____
Date

_____ _____ _____
Human Resources Name Signature Date