Waiver of Participation
for Health Insurance
(Name of Employer)

Dear _____, (Name of Employee)

Having met the eligibility requirements, you are being offered the opportunity to enroll in health coverage offered by _____ (name of Employer). You have the right to decline, or waive coverage.

The decision to waive coverage has consequences for you. For example:

- If you do waive coverage for yourself, you may not cover dependents under the Employer's health plan.
- If you waive coverage considered affordable and minimum essential under the Patient Protection and Affordable Care Act (ACA), you will not qualify for government credits and subsidies to purchase individual health insurance on the Marketplace.
- If you waive coverage, you cannot enroll in _____ (name of Employer)'s health plan until the next open enrollment, unless you experience a qualified change in status. Examples include if you are covered under another plan but that coverage is lost, or if you gain a new dependent through birth, adoption, or marriage. However, you must request to enroll in your plan within 30 days of the qualified change in status. If you miss the 30-day enrollment deadline, you must wait until open enrollment.

To be signed by employee:

I acknowledge that the Employer has offered me affordable minimum essential coverage, as defined under the ACA, for the period from _____ to _____. I have read the above, and I understand the consequences of my waiver of coverage. At this time, after careful review, I elect NOT to enroll in the major medical coverage offered by the above-named employer.

Employee Name:_____
(Please Print)

_____ _____
Employee Signature Date