

## Waiver of Health Benefits Health Insurance Marketplace

### Employee Information

*Employee should complete*

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email \_\_\_\_\_

Current Household Size\* \_\_\_\_\_ Annual Household Income\* \_\_\_\_\_

Current Medical Trust Health Plan \_\_\_\_\_ Termination Date \_\_\_\_\_

*\*Insert household size/annual household income from your Marketplace Application.*

### Employer Information

*Employer should complete*

Organization Name \_\_\_\_\_

Employer Identification Number (EIN) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

Current monthly contribution towards Employee Health Coverage \_\_\_\_\_

### Employee Acknowledgment

By signing below, I acknowledge:

- I have been offered health benefits coverage through the Denominational Health Plan from my employer.
- I decline enrollment/am terminating my current coverage at this time because I am purchasing a health plan through either the federal or state health insurance Marketplace and can establish that I am eligible to receive a premium tax credit.
- By purchasing a health plan through either the federal or state health insurance Marketplace, I understand that I forfeit (1) any employer contribution, if any, to a health plan through the Denominational Health Plan and (2) the pre-tax treatment of any personal contribution towards the cost of health coverage.
- I understand that if my household income increases during the year, I may be required to pay back all or a portion of the premium tax credit to the government.
- I acknowledge that there may be other financial considerations and personal tax consequences resulting from this decision and I acknowledge that I have been advised to consult with my tax advisor at my own expense prior to executing this form.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

### Health Insurance Marketplace Information

*Attach a copy of documentation  
obtained from Marketplace*

Carrier Name \_\_\_\_\_ Policy Number \_\_\_\_\_

Monthly Premium \_\_\_\_\_ Projected Premium Tax Credit \_\_\_\_\_

Coverage Level    Single    Family \_\_\_\_\_

Plan Type \_\_\_\_\_ Effective Date \_\_\_\_\_

*Please return this form and the requested documentation to your diocesan administrator so that your health benefits through the Denominational Health Plan may be canceled in a timely manner.*