City of Marietta, Georgia
Waiver of Employer Coverage Affidavit **2023**

PLEASE PRINT

NAME:_____

FIRST **MI** **LAST**

EMPLOYEE NO:_____ **DEPT:** _____

ADDRESS: _____

CITY:_____ **STATE:**_____ **ZIP:**_____

Attestation of Other Qualifying Health Insurance Coverage

I certify that my dependents and I are covered by another qualifying health plan that conforms to the Affordable Care Act's (ACA) minimum value standard* for Calendar Year 2023. I certify that I will maintain coverage in a qualified health plan on an ongoing basis and I agree to notify the City of Marietta's Benefits Manager within 30 days if I lose coverage under the qualified health insurance plan.

I agree to waive the health insurance and dental premium contribution by the employer and receive a matched contribution of up to $500 annually into a medical reimbursement account, provided that I also contribute into that account.

I further certify that all information and documentation provided is accurate. I understand that any false, deceptive, or otherwise improper act may result in the cancellation of my participation in this program.

Important Information

This waiver is only effective for the plan year specified and must be renewed on an annual basis during Open Enrollment to continue participation in this program. If you waive coverage during this enrollment, you may later request coverage under the City of Marietta's health plan only if you experience a qualifying family status change or during the annual open enrollment period.

SIGNATURE_____ **DATE** _____

* The Affordable Care Act (ACA) establishes a minimum value standard of the benefits of a health plan. For a qualifying group health plan to meet the ACA's minimum value standards, the plan must cover at least 60 percent of the total allowed cost of benefits provided under the plan. Employees may refer to their plan's Summary of Benefits and Coverage document to determine if their coverage meets the law's minimum value standards.

TERMS AND CONDITIONS

Health Insurance Benefit Waiver - Terms and Conditions

If hired prior to November 1, 2006, the City of Marietta pays 100% of POS health insurance benefit premiums for employees and 80% for employees' covered family members' health insurance benefit premiums. If hired after November 1, 2006, the City/BLW will pay 85% of the single POS premium for employees and 80% for employees' covered family members' health insurance benefit premiums. By my signature, I am electing to waive this health insurance coverage for myself, as employee, and all my covered family members on record as of this date (if any), and choose, instead, the City of Marietta's matched contribution in my name not to exceed $500 per year into a flexible spending arrangement (FSA) for medical benefits as described below. I am also certifying that my dependents and I are covered by another qualifying health plan that conforms to the Affordable Care Act's (ACA) minimum value standard for Calendar Year 2023.

In order to qualify for this option, I understand that I must comply with all requirements listed below: I must submit a completed Waiver of Employer Coverage Affidavit to the Benefits Manager or his/her designee before I am eligible to participate.

I must notify the Benefits Manager or his/her designee within thirty (30) days of any qualifying event which would affect this agreement. This includes loss of other insurance coverage, which would require both my family, if previously covered, and myself to re-enter the City of Marietta's health insurance program. The City will offer either the same health coverage as is currently being terminated by this agreement, or its equivalent.

Qualifying Event is defined by the IRS regulations as: (1) marriage or divorce of the employee;
(2) death of the employee's spouse or dependent; (3) birth or adoption of the employee's child;
(4) commencement or termination of employment of the employee's spouse; (5) a switch from part-time to full-time status, or vice versa, by the employee or the employee's spouse; (6) an unpaid leave of absence taken by the employee or the employee's spouse; and (7) a significant change in the health coverage of the employee or spouse attributable to the spouse's employment.

I understand that if I do not notify the City of Marietta Benefits Manager or his/her designee within 30 days of the date of loss of other insurance coverage, I will be required to wait to regain health insurance with the City of Marietta until the next open enrollment period. In all cases, proof of the date of loss of health insurance will be required.

After meeting all of the above qualifications, I understand that in lieu of receiving the City's health insurance benefit for myself or my covered family members (if any), the City of Marietta will match my contribution into a flexible spending arrangement (FSA) in my name up to $500 per year to be used only for reimbursement of qualified medical expenses (as defined by IRS Code Section 213(d)) which are not paid for by the other insurance coverage.

Examples of reimbursable expenses include, but are not limited to co-pays for doctor visits and prescription drugs, birth control pills, chiropractor expenses, hearing aids, expenses over and above what health insurance will pay for dental work, eye exams, glasses/contact lenses and solutions. Note: Premiums for health insurance are specifically precluded as a reimbursable expense under this plan by the IRS. Visit www.tasconline.com about other qualified medical expenses.