DeSoto Memorial Hospital
WAIVER OF COVERAGE FOR 2022 PLAN YEAR

You may decline health coverage offered by the Employer, DeSoto Memorial Hospital. This is called a waiver of coverage. If you waive coverage for yourself, you may not cover dependents under the Employer's health plan.

Note that for 2022, if you decline this coverage considered affordable and meeting the minimum essential requirements 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.

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

- You should be aware of the individual responsibility requirement that took effect in 2014 under the ACA. If you refuse the offer of the Employer's health coverage for 2022 and do not obtain coverage on your own, you may be subject to a penalty.

- Unless you sign a waiver stating that you are covered under another plan, such as a spouse's plan, Medicaid, or Medicare, you cannot enroll in the Employer's health plan until the next open enrollment. However, if you are covered under another plan, but that coverage is lost, you can enroll in your Employer's health plan immediately. There's a time limit for enrolling after the other coverage is lost: you must enroll in your plan within 30 days of losing the other coverage.

- If you gain a new dependent through birth, adoption or marriage, you may enroll yourself, the new dependent, and the entire family at that time, but you must do so within 30 days of gaining the new dependent. If you miss the 30-day enrollment deadline, you must wait until open enrollment.

I acknowledge that the Employer has offered me affordable minimum essential coverage, as defined under the ACA, for the period from January 1, 2022 to December 31, 2022. I have read the above and I understand the consequences of my waiver of coverage.

Check the appropriate box for the reason for waiving coverage:
☐Coverage doesn't meet my needs ☐Do not want to be insured ☐ Participating on domestic partner plan ☐ Participating on spouse's plan ☐ Participating on parent's plan
☐Too expensive

_____	_____	_____
Name of Employee	Signature of Employee	Date

As a representative of the Employer, I received this Waiver of Coverage from the above employee on _____ (Date).

_____
Signature of the Employer Representative