QUESTAR III

HEALTH INSURANCE WITHDRAWAL CERTIFICATION
NON-REPRESENTED EMPLOYEES

I, (Please print name)_____do hereby exercise my option of withdrawing from the Agency's health insurance plan for the period _____, 20_____ through June 30, 20_____.

I UNDERSTAND THAT by my exercising this option the Agency is no longer required to contribute toward the cost of such insurance on my behalf for the balance of the school year. Furthermore, I understand that I may not rejoin any health insurance plan offered by the Agency to its employees until the next designated enrollment period, except under the conditions and according to the terms that are outlined in the Administrative Procedures on Health Insurance withdrawal.

As an eligible, full-time employee, as defined by the Affordable Care Act, of Questar III BOCES, you have received an offer of coverage under a policy of group health insurance. Questar III BOCES believes that the coverage offered to you satisfies its obligations under the Affordable Care Act. In particular, it is believed the health plan is affordable, meets Minimum Essential Coverage and meets Minimum Value.

I understand that by declining coverage offered by Questar III BOCES, I may not be eligible for any subsidies if I choose to purchase health insurance on the state operated health insurance exchange. I understand that if I decide to purchase health insurance on the stated operated health insurance exchange, that I will not be eligible for the employer contribution towards such coverage. I further understand that the Affordable Care Act (ACA) requires most individuals to have qualifying health care coverage each month and that I may owe a federal tax penalty if I fail to be covered.

I HEREBY ATTEST THAT I have read the above and the Administrative Procedures, and that I am exercising my option fully and freely.

Employee's signature: _____ Date:_____

THE INSURANCE COVERAGE FROM WHICH I OPT TO WITHDRAW is the following (Check one): INDIVIDUAL COVERAGE: _____ FAMILY COVERAGE: _____

If Family Coverage, list each dependent's name, D.O.B., and relationship to you:

_____

_____

_____

_____

I have provided proof of alternative health insurance coverage to the Questar Payroll Department in order to be eligible for the health insurance buyout.

Employee's signature: _____ Date:_____

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Payroll Certification: The employee whose signature appears above has presented evidence that she/he has alternative health insurance coverage.

Payroll office signature: _____ *Date:*_____