Waiver of Coverage under the RCAB Health Plan and Notice of Special Enrollment Rights

Employee Name: _____ _____
(Last) (First)

For the Plan Year effective July 1, 20_____, I am waiving coverage for:

☐ Myself

☐ Spouse

☐ Dependent(s) – Please list names: _____

I am waiving coverage because:

☐ I have coverage under my spouse's plan – name of spouse's plan: ___ _____

☐ I have other coverage – provider of other coverage: _____

The other coverage is: (circle one)

COBRA **Medicare** **TRICARE** **Mass Health/Medicaid** **Employer-Sponsored Group Plan**

Massachusetts Commonwealth Connector or other state exchange

☐ **Subsidized by Connector**

☐ **Not Subsidized by Connector**

Special Enrollment Notice and Certification – *Please review and sign below if you wish to waive coverage.*
By signing below, I certify that I have been offered medical coverage under the RCAB Health Plan for myself and my eligible dependents, if any. I am declining enrollment as indicated above. I understand that if I am declining enrollment for myself and/or my eligible dependents (including my spouse) because of other health insurance or group health plan coverage, I may be able to enroll myself and my eligible dependents in this plan if I lose, or my eligible dependents lose, eligibility for that other coverage (or if the employer stops contributing towards my or my eligible dependents' other coverage).

I understand that I must request enrollment no more than 30 days after the date the other health plan coverage ends (or after the employer stops contributing toward the other coverage). If I do not do so, I will not be able to enroll until my employer's next annual Open Enrollment period.

In addition, I understand that if I have a newly eligible dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my eligible dependent(s). However, I must request enrollment within 30 days after marriage, birth, adoption, or placement for adoption.

I understand that in order to request special enrollment or obtain more information, I should log in to MyEnroll at www.bostoncatholicbenefits.org. For assistance, I understand that I may contact the RCAB Benefits Office at (617) 746-5641 or benefits@rcab.org.

_____ _____
Signature of Employee Date of Signature