District Council 1707, Local 95
Head Start Employees Welfare Fund

ENROLLMENT WAIVER

I, the undersigned, hereby certify that I have been afforded an opportunity to enroll in the Group Health Insurance offered by DC 1707, Local 95 Head Start Employees Welfare Fund (the "Plan"). After careful consideration, I have decided to not enroll in the Plan, thereby waiving my right to such coverage.

I understand that I will not be able to enroll in the Plan at a later date unless I enroll during Open Enrollment, or I experience either (1) a Special Enrollment Event or (2) a Permitted Election Change Event (if adopted under the terms of the Plan). I certify that I have read and understand the attached Special Enrollment Events and Permitted Election Change Events that allow me to enroll in the Plan outside of Open Enrollment. Further, I understand that to prove I experienced such an event I must provide supporting documents as outlined in the Summary Plan Description ("SPD").

Note: Special Enrollment Events and Permitted Election Change Events that allow you to enroll, cancel, or otherwise change your coverage are described at length in the SPD, but the event's that permit you and your dependents to enroll in the Plan outside of Open Enrollment are summarized in the attached form. Please refer to your SPD for important deadlines and procedures to request enrollment, cancellation, or changes to your coverage.

I decline enrollment in the DC 1707, Local 95 Head Start Employees Welfare Fund and its health insurance plan because:

☐ Covered under another health plan; ☐ Other (_____).

Please mark the appropriate reason for waiving coverage. If "Other", please explain.

_____ _____
Employee Signature Date

_____
Print Name

_____
Home Address

_____ _____
Head Start Center Name Telephone Number

To be completed by Head Start Center Director/Bookkeeper

Head Start Center Code # _____

Head Start Center Name _____

Head Start Center Address _____

Above is certified by

Print Name _____ Title _____

Signature _____ Date _____

Please keep a copy and mail original form to:

DC 1707, Local 95 Head Start Employees Welfare Fund
420 West 45 th Street, 3rd Floor
New York NY 10036

District Council 1707, Local 95
Head Start Employees Welfare Fund

Attestation Form

Enter Your Name and Sign One of the Two below Statements

I, _____, acknowledge that I recently had a status change of Full Time to Part Time and I no longer expect to work at least 30 hours per week. I am currently enrolled in the Group Health Insurance offered by DC 1707, Local 95 Head Start Employees Welfare Fund (the "Plan"), but I no longer want to be enrolled in the Plan.

I acknowledge that I have enrolled or intend to enroll myself (and any related individuals who cease coverage due to my disenrollment in the Plan) in a plan that provides minimum essential coverage effective no later than the first day of the second month following the month that includes the date my enrollment in the Plan is revoked.

Signature _____

I, _____, acknowledge that I am either eligible for a Special Enrollment Period to enroll in a Qualified Health Plan through a Marketplace, or I seek to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period.

I acknowledge that I intend to enroll myself (and any related individuals who cease coverage due to my disenrollment in the Group Health Insurance offered by DC 1707, Local 95 Head Start Employees Welfare Fund (the "Plan")) in a Qualified Health Plan through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of my enrollment in the Plan.

Signature _____

I am aware that the Affordable Care Act's "Individual Mandate" requires me to enroll in a health care plan that provides minimum essential coverage, unless I am eligible for an exemption. Failure to follow the Individual Mandate may result in fees. For more information on the Individual Mandate fees and exemptions visit www.healthcare.gov/fees-exemptions.

Employee Name (Printed) _____

Employee Name (Signature) _____

Manager Name (Signature) _____

Date _____