# RCUH ACA Health Enrollment/Change Form (B-5A)

## OPEN ENROLLMENT (Effective July 1, 2021)

**Employee Name:**_____ **RCUH Employee ID #:** _____

## Medical Insurance Coverage

**Section I: Options** (Please also fill out Section II, and III if enrolling. Skip to Section IV if waiving)

☐ I would like to add/remove dependent(s)

☐ I do NOT want to enroll in the HMSA Comprehensive Medical Basic plan, thus my last day of coverage will be 6/30/21. I understand that I will need to fill out **Section IV** of this document.

**Section II: New Level of Coverage** ☐ Employee Only ☐ 2-Party ☐ Family

**Section III: Dependent Information**

**Proof of relationship documentation is required (i.e. Birth Certificate, Adoption Document etc.)**

| +/- | Dependent's Name | SSN / ITIN (Required for 12 months or older) | Date of Birth (mm-dd-yyyy) | *Dependent Relationship | Gender |
|---|---|---|---|---|---|
| | | | | ☐BC ☐AC | ☐F ☐M |

**The ACA defines "Dependents" as the employee's (1) Biological Child (BC) OR (2) Adopted Child (AC) through the end of the month in which the employee turns 26 years of age. It is RCUH's policy for you to provide proof of dependent status as listed below (i.e. Birth Certificate, Adoption Document, etc.)**

**Section IV: Waiver** (Please fill out only if waiving coverage)

In compliance with the Patient Protection Affordable Care Act (ACA), you are required to complete this form on or before May 14, 2021 (the end of RCUH's 2021 Open Enrollment Period) if you have decided to CANCEL or WAIVE health care coverage with RCUH. Employees who are currently waiving health benefits at this time must submit this form to RCUH Human Resources as an agreement that he/she is still opting to waive health coverage at this time. Individuals can obtain coverage in many ways, including by participating in RCUH's medical plans, purchasing insurance in the Federal Health Insurance Marketplace (HealthCare.gov), or by obtaining government health insurance such as Medicare Part A, Medicare Advantage plans, or Medicaid. More information about the Individual Shared Responsibility Payment can be obtained from the Internal Revenue Service's website: (http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision)

- I *(and if applicable, my eligible dependents)* am waiving coverage because

☐ I prefer not to have coverage (I am declining health insurance entirely)

☐ I have or will have coverage through the Federal Health Insurance Marketplace (HealthCare.gov)

☐ I have coverage such as Medicare, Medicaid, TRICARE, COBRA, Veterans Program, or other coverage recognized by the Secretary of Health and Human Services as minimum essential coverage

**Section V: Employee Certification**

- I certify that any dependent(s) listed above are legally recognized dependents (Biological or Adopted Child) under the ACA. I understand that it is the RCUH's policy that proof of dependent status is required and agree to submit documentation by the established deadlines. I also agree to inform the RCUH if my dependent's eligibility status changes in the future. Failure to do so may result in cancellation of benefits, and may include termination of my employment.
- I understand that RCUH has given me an opportunity to enroll in RCUH's Medical Plan for my eligible beneficiaries and myself, and if I am voluntarily declining enrollment as indicated above, I can only enroll in the future during RCUH's Open Enrollment Period or due to a Qualifying Event as defined by RCUH's Policy 3.520 RCUH Health Plans. I understand that I and (if applicable) eligible dependents will be ineligible for the Premium Tax Credit (PTC), since medical coverage was offered through RCUH (employer-sponsored coverage
- Information on this application is given to obtain insurance and is true and complete to the best of my knowledge and belief. I authorize my employer to set my effective dates of coverage and to deduct monthly employee contribution for each benefit plan from my salary, wages, or other compensation including any contribution increase, decrease, adjustment, or cancellation as required by the Health Plan Agreement under applicable laws, policies, and procedures. I and any listed dependent agree to abide by the provisions of the service agreement and/or medical insurance contract, health plan regulations, and ACA/IRS regulations. I agree to abide by the terms and conditions of the Group Plan Contract(s) issued to the Research Corporation of the University of Hawaii. I have read the COBRA General Notice and I understand my rights for Continuation of Health Coverage under COBRA. I also understand that I must inform my dependents covered under my health insurance of their rights.
- I understand that failure to comply with the above or providing inaccurate information or falsifying the information contained in this form may result in disciplinary action including termination of employment. Legal action may be brought against me and/or my Dependents for any losses, damages (including, but not limited to reasonable attorneys' fees and other legal expenses), financial or otherwise, due to false statements provided on this enrollment (or related) form or for failure to timely notify RCUH of changed circumstances as required. In addition, any health benefits (ex., monthly premiums, claims, etc.) paid by the RCUH health plans on behalf of the Employee's dependents will be reversed and become the responsibility of the Employee.

**Employee Signature:** **Date:**

RCUH will only accept WET SIGNATURES