Harvard Pilgrim Health Care

MA Health Care Coverage Waiver Form

Employer Company Name: _____

Employee Name: _____

On behalf of myself and my eligible dependents (if any), I waive the option to enroll in Harvard Pilgrim Health Care health insurance offered at this time by or through my employer for the following reason:

Waiving Group Health Coverage

(Please select one of the following)

- ☐ I am covered under another group plan as a spouse or dependent
- ☐ I am covered by the MassHealth, Medicare, or Veterans Program
- ☐ I am covered under another group plan sponsored by a second employer
- ☐ I am covered under another carrier's plan sponsored by this employer
- ☐ I am covered through a non-group, individual or private health care plan not offered through my employer
- ☐ I do not wish to participate in health care benefits at this time
  (I am declining health insurance entirely)

If the reason stated above for waiving coverage is that you have coverage elsewhere, please provide the following information:

Carrier Name: _____

Subscriber Name: _____

I affirm that the information I have provided on this form is true and complete to the best of my knowledge and belief. I understand that Harvard Pilgrim may either refuse to renew coverage or terminate coverage, retroactive to the effective date, for any material misinformation (including omissions) contained in this form.

I understand that any person choosing to enroll at a time other than during my employer's open enrollment must meet Harvard Pilgrim's requirements for eligibility and the special enrollment rights summarized below.

Employee Signature: _____ Date: _____

Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this health plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Special enrollment rights may also apply if you lose coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for state premium assistance under Medicaid or CHIP. An employee or Dependent who loses coverage under Medicaid or CHIP as a result of the loss of Medicaid or CHIP eligibility may be able to enroll in this Plan, if enrollment is requested within 60 days after Medicaid or CHIP coverage ends. An employee or Dependent who becomes eligible for group health plan premium assistance under Medicaid or CHIP may be able to enroll in this Plan if enrollment is requested within 60 days after the employee or Dependent is determined to be eligible for such premium assistance.

Combined MA Employee Health Insurance Responsibility Disclosure (HIRD) Form/Harvard Pilgrim Health Care Waiver Form

You are completing this form because one or more of the following apply:

- **You have declined to participate in your employer sponsored health insurance plan**
- **You have declined to participate in the employer's "Section 125 Cafeteria Plan" pre-tax purchasing arrangement**
- **You have declined to participate in the Harvard Pilgrim Health Care[1] health insurance plan(s) offered**

Employer Name: _____ **FEIN:** _____

Employer D/B/A: _____

Employer Address: _____

City | State | ZIP Code: _____

Employer: Please report the dollar amount of the employee's portion of the monthly premium cost of the least expensive individual health plan offered by the employer to the employee. $_____

Employee Name: _____

(Please enter "First" "Middle Initial" "Last Name" and "Suffix" if applicable)

Employees: please check the appropriate box for each question.

1. Were you offered employer subsidized health insurance? ☐ **Yes** ☐ **No**

   1a. If Yes, did you decline your employer subsidized health insurance? ☐ **Yes** ☐ **No**

2. Were you offered a "Section 125 Cafeteria Plan" to pay for health insurance? ☐ **Yes** ☐ **No**

   2a. If Yes, did you decline to use your employer's "Section 125 Cafeteria Plan" to pay for health insurance? ☐ **Yes** ☐ **No**

3. Do you have other health insurance? ☐ **Yes** ☐ **No**

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[1] This information applies to coverage underwritten or administered by Harvard Pilgrim Health Care or its affiliate HPHC Insurance Company.

The employer must retain this document for three (3) years and make it available upon request to the Division of Health Care Finance and Policy and the Division of Revenue as required by state regulation 114.5 CMR 18.00.

If used as a HPHC waiver form, page 2 must be submitted to HPHC as part of the new group submission.

Harvard Pilgrim Health Care

If declining Harvard Pilgrim Health Care health insurance, please answer the additional questions below:

4. On behalf of myself and my eligible dependents (if any), I waive the option to enroll in the Harvard Pilgrim Health Care plan offered at this time by or through my employer _____ for the following reason:

- ☐ I am covered under another group plan as a spouse or dependent
- ☐ I am covered by MassHealth, Medicare, or Veterans program
- ☐ I am covered under another group plan sponsored by a second employer
- ☐ I am covered by another carrier's health plan sponsored by this employer
- ☐ I am covered through a non-group, individual or private health care plan obtained on my own and not offered through my employer
- ☐ I do not wish to participate in any health care benefits at this time.

5. If you declined to enroll in the Harvard Pilgrim Health Care plan offered at this time because of other health care coverage listed above, please provide the following information:

Carrier Name: _____ Subscriber Name: _____

Employee Affidavit

I hereby affirm, under penalties of perjury that all the information provided herein is true to the best of my knowledge. I also understand that if I do not have health insurance I may be responsible for the full costs of all medical treatment, that I may forfeit all or a portion of my Massachusetts personal tax exemption and be subject to other penalties pursuant to M.G.L c. 111M, that the Employee Health Insurance Responsibility Disclosure (HIRD) Form contains information that must be reported in my Massachusetts tax return, and that I am required to maintain a copy of the signed HIRD Form.

Employee Signature **Date (MM/DD/YY)**

Notice of Special Enrollment Rights

If you have declined enrollment for yourself or for your dependents (including spouse) because of other health insurance coverage, you may in the future be able to enroll yourself and or your dependents in this health plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. Any person choosing to enroll later must meet Harvard Pilgrim Health Care's requirements for eligibility and for late enrollees.

Special enrollment rights may also apply if you lose coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for state premium assistance under Medicaid or CHIP. You or your dependent who loses coverage under Medicaid or CHIP as a result of the loss of Medicaid or CHIP eligibility may be able to enroll in this plan, if enrollment is requested within 60 days after Medicaid or CHIP coverage ends. You or your dependant who becomes eligible for group health plan premium assistance under Medicaid or CHIP may be able to enroll in this plan if enrollment is requested within 60 days after you or your dependent is determined eligible for such premium assistance.

The employer must retain this document for three (3) years and make it available upon request to the Division of Health Care Finance and Policy and the Division of Revenue as required by state regulation 114.5 CMR 18.00.

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