Hamilton College Medical Plan Waiver Form

About this form: With this form, you can waive your medical plan coverage.

PLEASE PRINT

SECTION A – PERSONAL INFORMATION	
Employee Name (last name, first name)	**Social Security Number**
Effective Date	**Marital Status**
	☐ Single ☐ Married ☐ Domestic Partner

SECTION B – MEDICAL WAIVER

☐ I am electing NO medical coverage.
Benefits from this election will be added to my taxable income.

You must check one box below to indicate your reason.

☐ I have medical insurance through my spouse/domestic partner's employer

☐ I am covered under a stand-alone medical policy (not through a group)

☐ Other _____

☐ I have medical insurance through Medicare or Medicaid

☐ I do not wish to have any medical coverage. I understand I will not receive the College's waiver payment if I do not have other coverage.

I understand that I must report any change in family status that may impact my medical plan coverage to Human Resources within 30 days of the event.

I further understand that the medical coverage that I am waiving is minimum essential coverage that is considered affordable and meets the minimum value requirements of the Affordable Care Act. I understand that as a result of this coverage offer by the College, I may not be eligible for a premium tax credit if I obtain coverage through an Exchange (Marketplace) plan.

I certify that the information provided on this Medical Plan Waiver Form is true and correct and will be relied upon by the College.

Sign here if you are declining medical coverage.

_____ _____

Employee Signature ***Date***