EPISCOPAL CHURCH MEDICAL TRUST

# The Episcopal Church Medical Trust
## Waiver of Health Benefits
## Health Insurance Marketplace

**Employee Information (Employee Should Complete)**

| | | |
|---|---|---|
| Employee Last Name | Employee First Name | |
| Employee Address | Employee Phone Number | |
| Employee City | Employee State | Employee Zip |
| Employee Email Address | Current Household Size* | Annual Household Income* |
| Current Medical Trust Health Plan | Medical Trust Plan Termination Date | |

*Insert the Household Size and Annual Household Income you used on your Marketplace Application.

**Employer Information (Employer Should Complete)**

| | | |
|---|---|---|
| Employer Name | Employer Identification Number (EIN) | |
| Employer Address | Employer Phone Number | |
| Employer City | Employer State | Employer Zip |
| Employer Email Address | | |
| Current Contribution towards Employee Health Coverage (Enter employer monthly contribution) | | |

**Employee Acknowledgement**

By signing below, I acknowledge

- I have been offered health benefits coverage through the Denominational Health Plan from my employer.
- I *decline enrollment/am terminating my current coverage* at this time because I am purchasing a health plan through the local health insurance Marketplace and can establish that I am eligible to receive a premium tax credit.
- By purchasing a health plan through the local health insurance Marketplace, I understand that I forfeit (1) any employer contribution, if any, to a health plan through the Denominational Health Plan and (2) the pre-tax treatment of any personal contribution towards the cost of health coverage.
- I understand that if my household income increases during the year, I may be required to pay back all or a portion of the premium tax credit to the government.
- I acknowledge that there may be other financial considerations and personal tax consequences resulting from this decision and I acknowledge that I have been advised to consult with my tax advisor at my own expense prior to executing this form.

Employee Signature _____ Date _____

**Note to Employee: This form and the requested documentation must be returned to your group administrator so that your health benefits through the Denominational Health Plan may be cancelled in a timely manner.**

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## Health Insurance Marketplace Information

(Please attach a copy of documentation obtained from Marketplace)

| Carrier Name | Policy Number | |
|---|---|---|
| Monthly Premium | Projected Premium Tax Credit | |
| Coverage Level (Single, Family, etc) | Plan Type | Coverage Effective Date |

**Note to Employee: This form and the requested documentation must be returned to your group administrator so that your health benefits through the Denominational Health Plan may be cancelled in a timely manner.**