MANCHESTER SCHOOL DISTRICT
SCHOOL ADMINISTRATIVE UNIT NO. 37
195 McGregor Street, Suite 201
Manchester, NH 03102
Telephone: 603.624.6300 • Fax: 603.624.6337

Dear Manchester School District AMP Employees:

AMP Personnel who drop their existing school district health insurance are eligible for a payment of $1,500. The payment will be paid to the member is not enrolled in health insurance provided by the school district or City of Manchester. If the insurance is dropped mid-year in relation to a qualifying event, the payment will be prorated.

To receive this payment you must complete the bottom portion of this form and also provide proof of other insurance.

AMP
INSURANCE WAIVER

I received and read a copy of the "Notice of HIPAA Special Enrollment Rights" (the Notice) at or before the time I was initially offered enrollment in Manchester School District Group Health Plan (the Plan). I am aware of the warning in the Notice that I will lose some special enrollment rights for myself and my dependents if I decline coverage because I or my dependents have other coverage, unless I give the Plan this written statement that the reason I am declining coverage is because I or my dependents have other coverage.

I am also aware that under the Individual Mandate of the Federal Affordable Care Act, all legal residents of the United States are required to have health insurance. Failure by me, my spouse and/or my dependents to have and maintain health insurance could result in a penalty from the IRS.

By signing this form, I decline coverage under the Manchester School District Group Health Plan for the people listed below. My reason for declining coverage for these people is that they have other coverage under another group health plan or health insurance.

I further acknowledge that by declining coverage, absent a valid HIPAA special enrollment event, I will be excluded from enrolling in the Manchester School District Health plan until the next open enrollment.

(List all the people whom you could cover under the Plan but are not covering because they have other coverage, including you, your spouse and/or your dependents. Use additional paper if necessary.)

Name	Relationship (Self, Spouse, Dependent)	Source of Other Coverage (Spouse's plan, Medicaid, etc.)

MEDICAL:

❑ I **DO NOT** wish to enroll in medical insurance coverage at this time. I may enroll during the next open enrollment, or when I have a qualifying event. I understand it is my responsibility to contact the Human Resources within 30 days of a qualifying event. I acknowledge that the Employer has offered me affordable minimum essential coverage, as defined under the ACA, for the period from July 1, 2016 to June 30, 2017. I have read the above and I understand the consequences of my waiver of coverage.

Article 6.H: Effective on the date of ratification of this Agreement, the District will pay one thousand five hundred dollars ($1500.00) to any bargaining unit member who terminates his/her existing health insurance coverage under the District's plans and who also provides satisfactory evidence that he/she has valid alternative health insurance coverage elsewhere.

_____ _____

Signature Date

_____ _____

Print Name Position

** Please enclose a copy of your proof of insurance letter.

SPECIAL ENROLLMENT NOTICE

This notice is being provided to insure that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive coverage at this time.

Loss of Other Coverage

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Example: You waived coverage because you were covered under a plan offered by your spouse's employer. Your spouse terminates his employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under our health plan.

Marriage, Birth, or Adoption

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, or placement for adoption.

Example: When you were hired by us, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this group health plan. However, you must apply within 30 days from the date of your marriage.

Medicaid or CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired by us, your children received health coverage under CHIP and you did not enroll them in our health plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this group health plan if you apply within 60 days of the date of their loss of CHIP coverage.

For More Information or Assistance

To request special enrollment or obtain more information, please contact:

Name	Human Resources
Address	195 McGregor Street, Suite 201,
City, State	Manchester, NH 03102
Telephone	603-624-6300