



## Waiver of Coverage under the RCAB Health Plan and Notice of Special Enrollment Rights

**Employee Name:** \_\_\_\_\_  
(Last) (First)

For the Plan Year effective October 1, 201\_\_\_\_, I am waiving coverage for:

- Myself
- Spouse
- Dependent(s) – Please list names: \_\_\_\_\_

I am waiving coverage because:

- I have coverage under my spouse's plan – name of spouse's plan: \_\_\_\_\_
- I have other coverage – provider of other coverage: \_\_\_\_\_

The other coverage is: (circle one)

**COBRA**                      **Medicare**                      **TRICARE**                      **Mass Health/Medicaid**                      **Employer-Sponsored Group Plan**

**Massachusetts Commonwealth Connector or other state exchange**

- Subsidized by Connector**
- Not Subsidized by Connector**

### **Special Enrollment Notice and Certification** – *Please review and sign below if you wish to waive coverage.*

By signing below, I certify that I have been offered medical coverage under the RCAB Health Plan for myself and my eligible dependents, if any. I am declining enrollment as indicated above. I understand that if I am declining enrollment for myself and/or my eligible dependents (including my spouse) because of other health insurance or group health plan coverage, I may be able to enroll myself and my eligible dependents in this plan if I lose, or my eligible dependents lose, eligibility for that other coverage (or if the employer stops contributing towards my or my eligible dependents' other coverage).

I understand that I must request enrollment no more than 30 days after the date the other health plan coverage ends (or after the employer stops contributing toward the other coverage). If I do not do so, I will not be able to enroll until my employer's next annual Open Enrollment period.

In addition, I understand that if I have a newly eligible dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my eligible dependent(s). However, I must request enrollment within 30 days after marriage, birth, adoption, or placement for adoption.

I understand that in order to request special enrollment or obtain more information, I should log in to MyEnroll at [www.bostoncatholicbenefits.org](http://www.bostoncatholicbenefits.org). For assistance, I understand that I may contact the RCAB Benefits Office at (617) 746-5641 or [benefits@rcab.org](mailto:benefits@rcab.org).

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Date of Signature