



2018 HACC MEDICAL PLAN CASH OPT-OUT AGREEMENT

As an employee eligible to participate in the HACC Flexible Benefits Program, I understand that I may elect to waive the medical benefit coverage, for which I am normally eligible, and receive compensation from the College in lieu of the medical coverage.

To be eligible for the cash opt-out payments, I understand that I must submit this completed form to the HR Department and that I must attach documentation that I will have coverage under another medical plan during the 2018 plan year. The documentation must clearly indicate the source of the other coverage and that the coverage period incorporates calendar year 2018.

This agreement must be renewed each January 1st and may only be modified, outside of the new hire or open enrollment period, due to the occurrence of a qualified life event. The benefit is paid on each pay date, following the receipt of the completed agreement and acceptable documentation. As a taxable benefit, it is subject to FICA, federal, state, and local tax and is not utilized to calculate retirement contribution eligibility.

NAME (please print) -
EMPLOYEE ID -
EFFECTIVE DATE OF ALTERNATE COVERAGE -

PLEASE indicate the type of employment status you are currently in:

Check	CURRENT EMPLOYMENT TYPE	# OF PAY DATES
<input type="checkbox"/>	12-month	26
<input type="checkbox"/>	9-month/41-week	26
<input type="checkbox"/>	Other	Varies

BY SIGNING BELOW, I CERTIFY THAT I UNDERSTAND AND AGREE TO THE FOLLOWING:

By signing and submitting this form, I elect to **WAIVE** my (family's) coverage under any medical plan offered by the College during the Plan Year beginning January 1, 2018 and ending December 31, 2018.

I understand that I am NOT eligible for the cash opt-out compensation if I obtain health coverage through the federally-facilitated Marketplace. I also accept that if I do not enroll in a health plan, I will NOT be eligible for the cash opt-out compensation and may be subject to a penalty under the Affordable Care Act.

Any COBRA rights for continuation of medical coverage for family members or myself are not applicable during the period of this waiver.

Payment of the medical cash opt-out compensation will cease when I lose my eligibility for the HACC medical insurance benefits or otherwise fail to meet requirements.

EMPLOYEE SIGNATURE -
DATE -

Optional Use Only:

I hereby choose to **redirect** the medical cash opt-out compensation elected above to a tax-deferred account under the College's 403(b) retirement plan.

Select the account into which funds are to be deposited: TIAA/CREF

Do you already have an existing 403b account with the selected carrier? Yes No

If you do not have an established HACC 403b account, you will need to do this before any of the cash opt-out compensation can be redirected. Please note the amount of compensation for the waived benefit must be taken into consideration for maximum annual deferral limit calculations under IRS Code if additional salary deferrals are made.

EMPLOYEE SIGNATURE -
DATE -