

ATTESTATION OF ENROLLMENT IN EMPLOYER SPONSORED GROUP HEALTH PLAN AND HOLD HARMLESS AGREEMENT

I certify by listing my name (and covered dependents names) below that each name listed has qualified health insurance coverage through (check all that apply):

_____ IBEW Local 236 Health & Benefit Fund or _____ Another Employer or _____ My spouse's (or other family member's employer or _____ Other Government sponsored plan that meets the ACA definition of Minimum Essential Coverage (MEC*).

IBEW Local 236 Participant Name: _____ Spouse's Name: _____

Dependent: _____ Dependent: _____

Dependent: _____ Dependent: _____

Dependent: _____ Dependent: _____

Name of other insurance carrier (if not enrolled in IBEW Local 236 Health & Benefit Fund): _____

Policy # or Participant Identification #: _____ Effective Date of Coverage: _____

IBEW Local 236 Participant Social Security Number: _____ IBEW Local 236 Participant Date of Birth: _____

Marital Status: _____ Single _____ Married _____ Widowed _____ Divorced

I hereby elect not to have: _____ my own _____ my spouse's and/or _____ my child(ren)'s (please check all boxes that apply) health insurance premiums withdrawn from my personal HRA account. I understand that by making this election, my own and/or my spouse's and/or my child(ren)'s health coverage under the IBEW Local 236 Health & Benefit Fund (the "Fund") will terminate on the effective date of other coverage (please provide dated proof of other coverage). I was given the opportunity to enroll myself and/or my spouse, and/or my child(ren) in the IBEW Local 236 Health & Benefit Fund's Group Health Benefits. By waiving my own and/or my spouse's and/or my child(ren)'s Health Insurance Benefit, I am not waiving any other Benefit offered by the IBEW Local 236 Health & Benefit Fund.

I understand that if I later wish to enroll myself and/or my spouse and/or my child(ren) for any coverage(s) waived, I can do so only during Open Enrollment or upon involuntary loss of coverage. I further understand that I must complete the proper enrollment forms at such time.

I have attached the following "Proof of Current Coverage" *:

_____ Employer/Insurer letter of coverage _____ Insurance ID Card _____ Other (Please describe): _____

Please note if this is your first time opting out you will also need to complete the IBEW Local 236 Health & Benefit Enrollment (change) form and supply proof with the exact date that your new coverage began.

In consideration of my being allowed to make this election, I hereby agree, for myself and/or my eligible dependents, to indemnify the Fund, the Trustees of the Fund and their participants, agents and representatives, and hold them harmless, against any damages, costs or expenses which they may suffer or incur, including reasonable attorney's fees, arising out of any actions, causes of action or claims for or relating to benefits to which I or any of my eligible dependents would have been entitled had I not made this election. This Agreement shall be binding upon my heirs, executors, administrators and assigns, and shall inure to the benefit of the Fund, its Trustees, Participants, Agents and Representatives, and their successors and assigns.

Participant Signature _____ Print Name _____ Date _____

SPOUSAL SIGNATURE MUST BE NOTARIZED - IBEW Local 236 Participant's signature does not.

Spouse's Acknowledgement: (required if waiving coverage) **I certify that I am the spouse of:** _____ and I hereby consent to the foregoing Election and Hold Harmless Agreement.

Spousal Signature _____ Print Name _____ Date _____

NOTARY PLEASE COMPLETE: STATE OF: _____

COUNTY OF: _____

On the _____ day of _____ in the year 20_____

Notary Stamp or Seal:

before me, the undersigned personally appeared _____ (name of person you are notarizing) who is personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name are/is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her/their capacity(ies), and that by his/her signature on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

Notary Signature: _____

IBEW LOCAL 236 HEALTH & BENEFIT FUND

HEALTH PLAN AND HRA PLAN ENROLLMENT/WAIVER/OPT-OUT FORM AND HOLD HARMLESS AGREEMENT

Waiver Instructions: If you have other Affordable Care Act (ACA) Qualified Health Insurance coverage in effect through your spouse's or other family member's Employer-Sponsored Group Health Plan, you must complete and return Section One of this Form to the IBEW Local 236 Benefit Fund Office with either 1.) a copy of your insurance card that specifically identifies you as a covered dependent or 2.) a letter of coverage verification (which includes your name and policy/participant number) from your spouse's or other family member's insurance carrier.

Section One: Please check all applicable boxes below.

- Option 1: Participant ONLY Health Plan and HRA.** I am enrolled in a health plan offered by IBEW Local 236 Health & Benefit Fund as of 1/1/2018. I elect to be enrolled in our Health Reimbursement Account (HRA) Plan. This HRA will reimburse me for my personal qualified medical, dental and/or vision Expenses. By choosing this option, I agree to have my IBEW Local 236 Health & Dental premiums deducted from my HRA. **Example: I have single insurance coverage through the IBEW Local 236 Health & Benefit Fund and I want to be eligible for reimbursement.**
- Option 2: Participant and Family Health Plan and HRA.** My family and I are enrolled in a health plan offered by the IBEW Local 236 Health and Benefit Fund and I elect myself and my family to be enrolled in my Health Reimbursement Account (HRA) Plan. This HRA will reimburse myself and my covered dependents' for our personal qualified medical, dental, and/or vision expenses. By choosing this option, I agree to have my IBEW Local 236 Health & Dental premiums deducted from my HRA. **Example: I have 2-Person or family insurance coverage through the IBEW Local 236 Health & Benefit Fund and I want myself and my dependents to be eligible for reimbursement.**
- Option 3: Participant Health Plan Opt-Out with HRA Enrollment.** I am enrolled in a health plan offered by another employer (i.e. your spouse's employer or other family member's employer or a retiree plan) and I elect to Opt-Out of the IBEW Local 236 Health Insurance but wish to be enrolled in the IBEW Health Reimbursement Account (HRA) Plan. This HRA will reimburse me (and any dependents who are also enrolled in a Qualified Health Plan) for qualified medical, dental and/or vision expenses and post-tax deductions for the employer sponsored health plan that I am enrolled in. **Example: I am opting out of insurance coverage through the IBEW Local 236 Health & Benefit Fund because I have other employer sponsored health insurance and I want myself and my dependents to be eligible for reimbursement. Proof of other health plan enrollment is required. Please see the attestation form.**
- Option 4: Participant ONLY enrolled in the IBEW Local 236 Health Plan with a Spouse and/or other dependents enrolled in the HRA:** I am enrolled in a health plan offered by the IBEW Local 236 Health & Benefit Fund and my spouse and/or my dependents are not enrolled in a health plan offered by the IBEW Local 236 Health & Benefit Fund, but are enrolled in a health insurance plan offered by another employer (i.e. your spouse's employer or other family member's employer or a retiree plan). I elect myself, my spouse, and my other dependents to be enrolled in my Health Reimbursement Account (HRA) Plan. This HRA will reimburse myself, my spouse and my other dependents for our personal qualified medical, dental and/or vision expenses. By choosing this option, I agree to have my IBEW Local 236 Health & Dental premiums deducted from my HRA. **Example: I have single coverage through the IBEW Local 236 Health & Benefit Fund, my spouse and children have health insurance through another employer sponsored plan and I want myself, my spouse and my dependents to be eligible for reimbursements. Proof of other health plan enrollment is required. Please see the attestation form.**
- Option 5: Participant and/or Spouse enrolled in the IBEW Local 236 Health Plan or other sponsored health plan and dependent waiver:** I and my spouse and I am/are enrolled in a health plan offered by the IBEW Local 236 Health & Benefit Fund or another employer sponsored health plan and my dependents are NOT enrolled in a health plan offered by the IBEW Local 236 Health & Benefit Fund or a health insurance plan offered by another employer and I choose to waive my dependents from my Health Reimbursement Account (HRA) Plan. **Example: my children are enrolled in Child Health Plus, or Medicaid and not eligible for reimbursement under my plan. I want myself and/or my spouse to be eligible for reimbursement. Proof of other health plan enrollment is required. Please see the attestation form.**
- Option 6: Dependent Waiver:** My dependents are enrolled in a health plan offered by the IBEW Local 236 Health & Benefit Fund or a Health Insurance Plan offered by another employer and I choose to waive my dependents from my Health Reimbursement Account (HRA) Plan. This HRA will not reimburse me for my dependents' qualified medical, dental and/or vision expenses. **Example: My children are on my insurance plan or my spouse's plan but I DO NOT want them to be eligible for reimbursement. Proof of other health plan enrollment is required. Please see the attestation form.**
- Option 7: Permanent HRA Waiver:** (This option is required to be offered however it is highly unlikely that you would choose this option, unless you are in the instance of where you wish to only use the exchanged and be eligible for the federal subsidies associated and available on the marketplace.) I am not enrolled in a health plan offered by the IBEW Local 236 Health & Benefit Fund or a health insurance plan offered by another employer (i.e. your spouse's employer or another family participant's employer plan) and I elect to waive myself and my dependents from the IBEW Local 236 Health Reimbursement Account (HRA) Plan permanently. **Proof of other health plan enrollment is required. Please see the attestation form.**