Employee Form to Decline HCAP Coverage

Health Care Assistance Plan for Employees of the Seventh-day Adventist Organizations of the North American Division Working in the United States

I understand that I am an employee eligible to participate in the Health Care Assistance Plan for Employees of the Seventh-day Adventist Organizations of the North American Division Working in the United States ("Plan"). By signing this form, I hereby (1) decline coverage under the Plan; and (2) certify to my employer that I have health plan or health insurance coverage from another source, such as a health plan sponsored by the employer of my spouse or parent, or a federal plan, such as Medicare or Medicaid. I have attached proof of such other coverage to this Form.

By declining coverage for myself as an employee, I understand that my spouse and dependent children ("Dependents") are not eligible for coverage under the Plan. I understand that my ability to enroll myself and my Dependents in the Plan at a later date may be restricted to certain time periods, such as (1) an open enrollment period of my employer; and/or (2) the special enrollment periods described in the Plan.

I also acknowledge, represent and agree that:

1. since I am eligible for Plan coverage, my tax dependents and I will not qualify for any federal subsidy (premium tax credit) available for health insurance purchased at a Health Insurance Marketplace (for more information about the Health Insurance Marketplaces, visit www.healthcare.gov);
2. I am signing this form voluntarily and I am not required by my employer or the Plan to sign this form; and
3. I have not been given and will not be given any incentive, reward or consideration by my employer or the Plan for signing this form.

Signature: _____

Print Name: _____

Date: _____