Benefits Acknowledgement

This is to acknowledge that I have been given the opportunity to enroll in the Minimum Essential Coverage employee only benefits from the City of Springfield. I have been informed and have received benefit-related materials from my employer with coverage information.

I understand that:

Coverage is entirely voluntary;

I must complete the enrollment form or decline the Minimum Essential Coverage plan. If I do not enroll, or am late in submitting my enrollment form, I may elect to participate during the next annual open enrollment period;

My failure to complete the enrollment process during the annual open enrollment period will be interpreted as declining coverage.

If I decide to enroll at a later date, it must occur during a qualifying life changing event or during the next annual open enrollment period.

If I later decide to stop coverage, I understand it must occur within 50 days of a qualifying life changing event or during the annual open enrollment period. I further understand that I must complete and submit my enrollment change request and supporting documentation directly to the City of Springfield Benefits Department.

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), I may have the right to continue receiving benefits even if I am no longer an employee. In that case, however, I must pay for the total cost of coverage and the employer is permitted to cancel the coverage in certain circumstances. **I understand that if I elect to decline to participate in the benefits, I will not have an opportunity to obtain coverage after my employment ends.**

I understand that I am **NOT AUTOMATICALLY ENROLLED** without going through the enrollment process with the City of Springfield and that my failure to enroll within ten days of my hire date may prevent my enrollment and/or participation in the benefits until Open Enrollment or a qualifying event.

Use this form to decline coverage under the MEC Plan; please return this form to the City of Springfield's Benefit Department.

EMPLOYEE NAME (PRINT) **LAST FOUR DIGITS OF SOCIAL SECURITY #**

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EMPLOYEE SIGNATURE_____**DATE**_____