FAMILY ADVANTAGE HEALTH PLAN (FAHP): ENROLLMENT AFFIDAVIT

This affidavit applies to individuals who participate in the Family Advantage Health Plan (FAHP), who are waiving coverage under this Employer's Group Health Plan. A signed affidavit is required for each Plan Year in which an individual and/or their eligible dependents are enrolled in this FAHP.

EMPLOYER NAME:	
EMPLOYEE NAME:	
PLAN YEAR:	

By signing below, I certify that for the Plan Year listed above:

- My employer has offered me and my eligible dependents (spouse, children under age 26, and disabled children over age 26) the opportunity to enroll in an employer-sponsored group health plan that does not consist solely of "excepted benefits" under the 2010 Patient Protection and Affordable Care Act.
- I am waiving enrollment for myself and/or my eligible dependents in my employer's group health plan, as indicated on the FAHP enrollment form.
- The individuals that I have enrolled into this Plan through the FAHP Enrollment Form **are enrolled** in a group health plan through my spouse's employer, my parent's employer, or other accessible group health plan henceforth being referred to as the "Primary Medical Plan". ***The enrollment effective date of the Primary Medical Plan coverage must be before or coincide with the effective date of the FAHP.***
- I was enrolled in this FAHP during the previous plan year, or that I have previously met the requirement of having been enrolled in my employer-sponsored group health plan for 12 or more months.

I further certify that the Primary Medical Plan:

- Does not include active contributions into a health savings account (HSA).
- Is not through Medicare, Medicaid, Tricare, an Individual Policy, or a Limited Benefit Health Plan.
- Does not consist solely of "excepted benefits" under the 2010 Patient Protection and Affordable Care Act (such as limited-scope dental or vision coverage), nor does it consist solely of a "health reimbursement arrangement" (reimbursement of health care expenses up to a dollar limit).

I understand that any questions that I have regarding the Primary Medical Plan (including its compliance with the IRS definition of minimum value) will need to be direct to the HR Department of my spouse's employer.

EMPLOYEE SIGNATURE:		**DATE:**	
SPOUSE SIGNATURE:		**DATE:**	

PLEASE SEND YOUR COMPLETED/SIGNED ENROLLMENT AFFIDAVIT TO YOUR HR DEPARTMENT.