THE STATE OF FLORIDA

JUSTICE ADMINISTRATIVE COMMISSION

Post Office Box 1654, Tallahassee, FL 32302 Telephone: 850-488-2415 Fax: 850-922-6794

New Hire Insurance Waiver Form

Employee Information – All Fields Required:

People First ID: 0 0

First Name:

Last Name:

☐ **WAIVE** My Health Insurance

I understand that I am waiving my option to participate in the State of Florida Group Health Insurance and that my decision is subject to applicable rules in Chapter 60P, Florida Administrative Code and the federal Patient Protection and Affordable Care Act.

I understand that my election to waive health insurance will remain in effect for the remainder of the calendar year and can only be changed during Open Enrollment or if I have a Qualified Status Change event as defined by the federal Internal Revenue Code and/or the Florida Administrative Code.

I understand that I must make all changes through People First. Allowable changes include enrolling, changing plans, canceling coverage, and adding or dropping dependents. I understand that I must request such changes within 60 calendar days of the Qualifying Status Change event.

I further understand that if I can afford to enroll in health insurance but choose not to do so, I will be required under federal law to pay a fee ("individual shared responsibility payment") unless I qualify for an exemption from said payment.

Employee Signature: _____ Date: _____