UNC HUMAN RESOURCES

Health Insurance Coverage
Acknowledgement of Offer and Optional Waiver to Decline Coverage

<u>Section 1</u> – ***To be completed by Human Resources Representative (HR Rep) when employee listed below becomes eligible for health insurance coverage (e.g., at time of hire)***

Name of HR Rep Completing Form: _____

Employee Name and PID: _____

Position: _____

Date of Hire:_____

Hours per week employee expected to work or full time equivalency ("FTE"): _____

Employee expected to work for ninety (90) days or less? ☐ Yes ☐ No
If yes, please contact Benefits Services to determine whether the employee is eligible for health insurance coverage.

Position is "seasonal" (position for which the customary annual employment is six (6) months or less, e.g., summer camp counselor)? ☐Yes ☐No

Subject to limited exceptions, employees expected to work thirty (30) or more hours per week (0.75 FTE or greater) are eligible for and must receive an offer of health insurance coverage under the Affordable Care Act (ACA). This includes hours worked at all campus jobs, including work in multiple units of The University of North Carolina at Chapel Hill (UNC –CH) as well as at other constituent institutions of The University of North Carolina (UNC). UNC-CH and/or UNC may be subject to federal penalties for failure to comply with the ACA.

Employee listed above is benefit-eligible because he/she is being hired initially to work 30 or more hours per week? ☐ Yes ☐No

If yes, I have confirmed the employee has received information about how to enroll in the North Carolina State High Deductible Health Plan:

HR Rep Initials _____ Date: _____

Disclaimer: This form is used for tracking purposes only. It does not alter any terms or conditions of employment or create a contract between the University and any employee.

Section 2 – ***To be completed by employee at time of hire or time of measurement if employee is determined to be eligible for health coverage.***

I currently work for another unit of UNC-CH and/or another constituent institution of The University of North Carolina (for a list of constituent institutions, please visit www.northcarolina.edu):

☐ Yes ☐No

If yes, please list other unit or constituent institution: _____
and number of hours per week or FTE worked for the other unit or constituent institution: _____.

I acknowledge that the information I have provided on this form is accurate to the best of my knowledge.

If benefit-eligible:

UNC-CH believes that the coverage offered to me satisfies its obligations under the ACA. If I decline such coverage and do not have other coverage, I understand that there may be consequences under the ACA such as assessment of a tax penalty.

I acknowledge that my next opportunity to obtain coverage through this job for myself, my spouse, and/or my dependent children will come with a qualifying event or at the next Annual Open Enrollment period, assuming I remain employed in an eligible position with UNC-CH. If I decline coverage, I understand that I will not be eligible for COBRA continuation coverage if my employment should end during the period of coverage I have declined.

I certify that I have been informed of the availability of coverage under the North Carolina State High Deductible Health Plan (www.shpnc.org) and I certify that:
☐ I will complete the necessary forms to obtain such coverage.
OR
☐ I decline to enroll in the North Carolina State High Deductible Health Plan (my employer's health benefit plan) for the following reason:

☐I have other medical coverage provided by: _____

☐I do not wish to enroll myself in any type of medical coverage at this time, and I am aware of the possible consequences under the ACA.

☐Other (please describe): _____

Employee Name (Printed):_____

PID: _____

Date of Hire:_____

Employee Signature: _____

Date: _____

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