Rockingham County

BUYOUT ATTESTATION FORM

Plan Year July 1, 2024 - June 30, 2025

NOTE: YOU ARE ONLY ELIGIBLE FOR THE BUYOUT IF YOU ARE COVERED BY A NON-COUNTY MEDICAL INSURANCE PLAN.

1. I understand the County is making a qualifying offer of coverage in accordance with the Employer Mandate of the ACA. The benefits of the Plans have been thoroughly explained to me and I understand that by signing this form I am voluntarily waiving coverage for myself and my eligible dependents. I certify that my dependents and I (for whom I am waiving coverage) are enrolled in other group health coverage that is deemed to be minimum essential coverage. I understand that if I choose to opt-out of coverage and elect Buyout, the Buyout payments will be taxable. Additionally, I understand that I can use this compensation for any purpose, but these monies are not intended to reimburse me for an individual plan in the marketplace.

2. I understand that I may enroll into one of the County's group medical plans only during the annual Open Enrollment period as determined by Rockingham County or during a "special enrollment period" (Change in Status). A "special enrollment period" is a period of time you may be able to elect to enroll yourself and/or dependent (s) after one of the following events occurs:

- **Loss of other medical insurance coverage** – You may be able to enroll yourself and/or your dependent (s) provided that you request enrollment within **thirty (30) days** after such other coverage ends. In the case of COBRA continuation coverage, you may be eligible for a special enrollment period if the COBRA coverage is exhausted. A special enrollment period is not available if coverage under your prior plan or COBRA coverage was terminated for failure to timely pay the required premiums.
  Internal Revenue Service (IRS) guidelines state that the loss of coverage through an individual health plan does not constitute a valid "Change in Status" event.
- **Acquiring a new dependent** – If you acquire a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and/or your dependent(s) provided that you request enrollment within **thirty (30) days** after the date of marriage, birth, adoption or placement for adoption.

3. I understand that I **MUST maintain other Non-County health coverage to remain eligible for the Buyout**. It is my responsibility to notify the County if my other health coverage is terminated. I agree to return to the County all payments made in error or for fraudulent acts which include, but are not limited to: (a) failure to report a change and/ or changes in status affecting my eligibility to opt out of the Plan in a timely manner; (b) falsifying information in order to receive the Buyout. If I lose my other coverage at any time, or it is determined that I am not eligible for the Buyout, I authorize automatic repayment to the County through payroll deduction for any Buyout payments received for any period later determined ineligible.

4. In addition to myself, all of my eligible dependents must opt out of the Plan in order to receive the Buyout. In order to continue receiving the Buyout, I must opt-out of the Plan annually at Open Enrollment. By signing below, I am opting out of the Plan for the period of 7/1/2024 - 6/30/2025 only. If I have previously opted out of the Plan, and wish to enroll at the next open enrollment, I must submit an application for enrollment according to the parameters of that open enrollment.

5. Upon the **timely** receipt of this completed form, I understand my request will take effect **the first payroll of the month; the first day of the other coverage effective date** for a "Change in Status" request outside the Open Enrollment period; or **the first of the month following date of hire** for New Hires after 7/1/2024, whichever is applicable. I understand that there is a prorated rate for part time benefits eligible status.

By signing below, I certify that I acknowledge, understand, and agree to the foregoing statements, that I have Non-County coverage as defined herein, and that the County may request at any time proof of such coverage.

Employee Name (Print): _____

Employee #: _____

Employee Signature: _____

Date: _____ Daytime Phone Number: _____

Please Select One (1):

Open Enrollment election ☐

Change in Status Request (Outside the Open Enrollment Period) ☐

New Hire election ☐

Return original form to the Human Resources Department

HR USE ONLY

Effective Date: _____

Processed By: _____