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Catilize Health®

ATTESTATION OF ENROLLMENT
IN A NON-MCSIG EMPLOYER GROUP HEALTH PLAN

Employee Name: _____ Work Phone: _____

Work Location: _____ Email: _____

This form applies to individuals who participate in CompleteCare and who waive coverage in the MCSIG health plan.

Employees, spouse/domestic partners, and eligible dependents who are waiving coverage in the MCSIG health plan certify that:

-- MCSIG has offered me and/or my spouse/domestic partner and/or my eligible dependents a group health plan that does not consist solely of "excepted benefits" under the Affordable Care Act of 2010 ("ACA").

-- I and/or my spouse/domestic partner and/or my eligible dependents are enrolled in alternate coverage (such as my spouse/domestic partner's employer) that does not consist solely of "excepted benefits" under the ACA (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 by enrolling in CompleteCare, I am waiving participation in the MCSIG health plan for the following participants:

_____ _____
Name Name

_____ _____
Name Name

Attach a separate sheet if space is needed for additional participants

For confirmation that the alternate coverage meets the IRS's definition of minimum value and does not consist solely of an HRA, please contact the benefits coordinator at the other employer.

I further certify that my alternate coverage is not:

- A High Deductible Health Plan (HDHP) **with** active contributions to a health savings account (HSA); however, **it is acceptable alternate coverage** if contributions can be waived. A spouse/domestic partner who is not enrolled in CompleteCare Plan may contribute to an HSA and use the HSA funds.
- The HSA funds CANNOT be used for medical expenses for members enrolled in CompleteCare.
- Medicare, Tricare, VA health care or Medicaid
- Health Insurance coverage made available thru the Affordable Care Act
- An individual policy
- A Limited Benefit Health Plan
- Coverage through another MCSIG employee

_____ _____
Employee Signature Date

_____ _____
Spouse/Domestic Partner's Signature ONLY IF ELIGIBLE FOR COMPLETECARE Date

For more information, please contact Catilize Health @ 877-872-4232

PLEASE COMPLETE THIS FORM AND SEND TO:

Lisa Sierra – Benefits & Eligibility Specialist
76 Stephanie Drive
Salinas, CA 93901
lsierra@mcsig.com
Fax: 831-755-0172