



District Council 37, Local 95 Head Start
Employees Welfare Fund

Attestation Form

Enter Your Name and Sign One of the Two below Statements

I, _____, acknowledge that I recently had a status change of Full Time to Part Time and I no longer expect to work at least 30 hours per week. I am currently enrolled in the Group Health Insurance offered by DC 37, Local 95 Head Start Employees Welfare Fund (the "Plan"), but I no longer want to be enrolled in the Plan.

I acknowledge that I have enrolled or intend to enroll myself (and any related individuals who cease coverage due to my disenrollment in the Plan) in a plan that provides minimum essential coverage effective no later than the first day of the second month following the month that includes the date my enrollment in the plan is revoked.

Signature

I, _____, acknowledge that I am either eligible for a Special Enrollment Period to enroll in a Qualified Health Plan through a Marketplace, or I seek to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period.

I acknowledge that I intend to enroll myself (and any related individuals who cease coverage due to my disenrollment in the Group Health Insurance offered by DC 37, Local 95 Head Start Employees Welfare Fund (the "Plan")) in a Qualified Health Plan through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of my enrollment in the Plan.

Signature

I am aware that the Affordable Care Act's "Individual Mandate" requires me to enroll in a health care plan that provides minimum essential coverage, unless I am eligible for an exemption. Failure to follow the Individual Mandate may result in fees. For more information on the Individual Mandate fees and Exemptions visit www.healthcare.gov/fees-exemptions.

Employee Name (Printed) _____

Employee Name (Signature) _____

Manager Name (Signature) _____

Date _____