ATTESTATION OF ENROLLMENT

IN A NON-REEP EMPLOYER GROUP HEALTH PLAN

Employee Name:______________________________ Work Phone: ___________________________
Work Location: ______________________________ Email: ________________________________

This form applies to individuals who participate in the REEP CompleteCare and who waive coverage in the REEP Group Health Plan.

Employees, spouses and eligible dependents who are waiving coverage in the REEP Health Plan certify that:

-- REEP has offered me and/or my spouse, and/or my eligible dependents a group health plan that does not consist solely of "excepted benefits" under the Patient Protection and Affordable Care Act of 2010 ("PPACA").

-- I and/or my spouse, and/or my eligible dependents are enrolled in Alternate Coverage (such as my spouse's employer) that does not consist solely of "excepted benefits" under PPACA (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 for the CompleteCare participants in the REEP Health Plan for my covered CompleteCare enrollees as follows:

___________________________________ ___________________________________
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:

- High Deductible Health Plan (HDHP) **with** active contributions to a health savings account (HSA)
- Medicare, Tricare (Retiree only) or Medicaid
- Health Insurance Coverage made available thru the Affordable Care Act
- Individual policy
- Limited Benefit Health Plans
- You are NOT eligible if your Alternate Coverage is through another REEP employer.

____ ____________________
Employee Signature Date

____ ____________________
Spouse's Signature - ONLY IF ELIGIBLE FOR CompleteCare Date

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

PLEASE COMPLETE THIS FORM AND SUBMIT TO BENEFITS DEPARTMENT OR KEENAN

TO BE COMPLETED BY BENEFITS DEPARTMENT
REEP Medical Plan Rate: ___________________________ 10thly______ 11thly______ 12thly______
Effective Date:____
If current employee enrolled in medical plan – currently enrolled in a HMO ____ or PPO _____ New Hire____
Signature of Benefits Department Administrative Contact Date (mm/dd/yyyy)
X

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