



**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 Affordable Care Act of 2010 ("ACA").

-- 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 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 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); however, as long as your spouse is not enrolled in CompleteCare, your spouse may contribute to an HSA and use the HSA funds. The HSA funds CANNOT be used for medical expenses for members enrolled in CompleteCare. All members may use the HSA funds for dental and/or vision as long as those expenses are not covered by CompleteCare.
- Medicare, Tricare or Medicaid
- Health Insurance Coverage made available thru the Affordable Care Act
- Individual policy or 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 PPO Kaiser New Hire
HSA MVP
Signature of Benefits Department Administrative Contact _____ Date (mm/dd/yyyy) _____

X