GENERAL PURPOSE HRA

2018 VERIFICATION OF PROOF OF OTHER HEALTH INSURANCE

In order to be eligible to elect the **General Purpose Health Reimbursement Account (HRA)** after waiving KEHP health insurance coverage for plan year **2018**, you **MUST** sign this form attesting to the fact that you are enrolled in another group health insurance plan which provides minimum value under the Affordable Care Act.

Please check either A or B below:

A.)_____ By enrolling in the KCTCS General Purpose HRA, I declare that I am enrolled in another **group health plan** that provides **minimum value,** beginning January 1, 2018, including coverage under another agency participating in the Kentucky Employees' Health Plan (KEHP).

- A "group health plan" does not include individual policies purchased through the Marketplace (kynect/ healthcare.gov) or governmental plans such as TRICARE, Medicare or Medicaid.
- A group health plan that provides "minimum value" means the plan pays at least 60% of the total allowed cost of covered benefits/services, and participants or members in the plan are required to pay no more than 40% of the total allowed cost of covered benefits/services.

B.)_____I do **NOT** have health insurance coverage in a **group health plan** that provides **minimum value** beginning January 1, 2018. I understand that I am **NOT** eligible for enrollment in the General Purpose HRA and for its applicable employer credit. I understand that I may enroll in a either a health plan offered by KCTCS under the KEHP or in the **Waiver Dental/Vision ONLY HRA** offered by KCTCS instead.

I UNDERSTAND THAT <u>IF I DO NOT SIGN THIS FORM</u>, I WILL NOT BE ELIGIBLE FOR THE GENERAL PURPOSE HRA OR THE EMPLOYER CREDIT, AND I MUST SIGN UP FOR A HEALTH PLAN OFFERED BY KCTCS UNDER THE KEHP OR THE WAIVER DENTAL/VISION ONLY HRA.

_____ _____

Employee Name (print) EID #

_____ _____

Signature and Date SSN

_____

College

The above-named employee refused to sign this form

_____ _____

Human Resources Representative Date