Declination of Healthcare Coverage Affidavit

I hereby certify that:

1. I have been given an opportunity to fully participate in the group medical plans provided through Miami-Dade County Public Schools (M-DCPS) and have elected to decline to participate in the group insurance plans.
2. I am currently enrolled in other minimum essential coverage (but not individual coverage) that is primary.
   - Group healthcare coverage
   - State-funded coverage (Medicare, Medicaid, TRICARE)
3. I understand that if I desire to apply for medical insurance at a later date, I may enroll only during an annual enrollment period determined by M-DCPS or during a "special enrollment period" (Change in Status) following an IRS acceptable change in status event. In case of COBRA continuation coverage, you may be eligible for a special enrollment period if the COBRA coverage is exhausted. A special enrollment period is not available if coverage under your prior plan or COBRA coverage was terminated for cause or as a result of failure to pay any contributions toward the cost of coverage on a timely basis.

   NOTE: Internal Revenue Service (IRS) guidelines state that the loss of insurance through an individual healthcare plan does not constitute a valid Change in Status event.
4. I understand that I will not be enrolled in a Board-Paid medical plan. I will receive Board-Paid Standard Short-Term Disability, Basic life and $100 per month, paid through the payroll system. (This is subject to withholdings and FICA.)
5. I understand that I must provide current proof of other active group healthcare or State-funded coverage. Otherwise, I will be auto-assigned Cigna SureFit plan (employee-only) coverage. Selection of a Primary Care Physician (PCP) is required. If I do not select a PCP, Cigna will assign me a participating provider based on my zip code.

I have read, understand and agree to comply with the requirements stated above. Additionally, current proof of other group or state funded healthcare plan coverage is being submitted with this Affidavit. The proof must include:

- Date coverage became effective
- Enrollment in a healthcare plan (i.e. ID card, enrollment confirmation or verification letter)
- Your name as a covered member
- Group number or name of the group or state funded healthcare plan

NOTE: M-DCPS' healthcare coverage meets affordability and minimum value standards; therefore, you are ineligible for financial assistance (premium tax credits) to purchase Exchange/Marketplace coverage. Individual Exchange/Marketplace healthcare coverage are not eligible to receive opt-out money based on the Affordable Care Act (ACA) Rules on Employer-Sponsored Coverage.

Print Name _____ Employee Number _____

Signature _____ Date _____

This Affidavit must be submitted with current proof of other group or state-funded healthcare coverage, even if previously submitted. Please fax this affidavit and proof of other group or state-funded healthcare coverage to 1 (866) 879-8689. Please note, the sole submission of these documentation, does not mean that you have elected to decline healthcare coverage. You must either complete your online enrollment or submit your enrollment if you have experienced a qualifying permitted election change event.