# HACC Medical Plan
# Cash Opt-Out Form

Employee ID: _____ Employee Name: _____

As an employee eligible to participate in the HACC Flexible Benefits Program, I understand that I may elect to waive the medical benefit coverage, for which I am normally eligible, and receive compensation from the College in lieu of the medical coverage.

**To be eligible for the cash opt-out payments, I understand that I must submit this completed form to the Office of Human Resources and that I must attach documentation that I will have coverage under another medical plan during the plan year.** The documentation must clearly indicate the source of the other coverage and the coverage period.

This agreement must be renewed each January 1st and may only be modified outside of the new hire or open enrollment period due to the occurrence of a qualified life event. A portion of the benefit is paid on each pay date, following the receipt of the completed agreement and acceptable documentation; retroactive payments will not be made. As a taxable benefit, it is subject to FICA, federal, state, and local tax, and is not utilized to calculate retirement contribution eligibility. Payment of the medical cash opt-out compensation will cease when I lose my eligibility for the HACC medical insurance benefits or otherwise fail to meet requirements.

BY SIGNING BELOW, I CERTIFY THAT I UNDERSTAND AND AGREE TO THE FOLLOWING:
By signing and submitting this form, I elect to **WAIVE** my (family's) coverage under any medical plan offered by the College during the plan year (calendar year) _____ .

I understand that I am NOT eligible for the cash opt-out compensation if I obtain health coverage through the federally-facilitated Marketplace. I also accept that if I do not enroll in a health plan, I will NOT be eligible for the cash opt-out compensation and may be subject to a penalty under the Patient Protection and Affordable Care Act. Any COBRA rights for continuation of medical coverage for family members or myself are not applicable during the period of this waiver.

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**Optional:** (Only check the box if you want to put the funds into your TIAA account instead of your paycheck):

□ I hereby choose to **redirect** the medical cash opt-out compensation elected above to a tax-deferred account under the College's 403(b) TIAA retirement plan.
Do you already have an existing 403b account with TIAA? □ Yes □ No

If you do not have an established HACC 403b TIAA account, you will need to do this before any of the cash opt-out compensation can be redirected. Please note the amount of compensation for the waived benefit must be taken into consideration for maximum annual deferral limit calculations under IRS Code if additional salary deferrals are made.

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Employee Signature: _____ Date: _____

Upload completed form to your employee file in Streamlink. - instructions can be found **here**
and on myHACC > Human Resources > Compensation and Benefits.
Contact AskHR@hacc.edu for assistance.