Wespath
BENEFITS | INVESTMENTS

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HealthFlex Waived for Medicare/Medicare Supplement

Please accept this document as notification that I elect to decline HealthFlex coverage as offered by my Salary Paying Unit (employer) for:

- ❒ Myself (and by doing so, any eligible dependents)
- ❒ My spouse

Instead, the individuals noted above elect to enroll or retain coverage in Medicare, with any supplemental medical coverage we may select.

I (and/or my spouse, if applicable) independently make this election without any encouragement, coercion or incentive from my Salary-Paying Unit. If there is any employer or conference cost share available for a Medicare supplement plan, including any Health Reimbursement Account (HRA) I have related to Medicare supplemental coverage through Via Benefits™, I will not be eligible for that funding.

I (and/or my spouse, if applicable) understand that by declining health coverage, I am/we are declining coverage for the balance of the current plan year (calendar year) and all subsequent plan years unless I enroll for such coverage during a subsequent Annual Election period for coverage commencing on the following January 1. In certain circumstances, I may be able to enroll for coverage for myself or eligible dependents prior to a subsequent Annual Election period. These circumstances include losing eligibility for the advanced Premium Tax Credit under the Affordable Care Act (ACA), or due to marriage, birth, adoption or legal guardianship, or loss of other health insurance as provided under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and change of status rules under HealthFlex. I understand the above and still wish to decline coverage for the individual(s) noted above.

I hereby acknowledge that in executing this document, I am declining coverage in HealthFlex for the individuals noted above and releasing Wespath Benefits and Investments, its constituent corporations, directors, officers, attorneys and employees for liability to me, my spouse, my alternate payee, my heirs, named beneficiaries or successors in interest, for any damages which result from any action or omission taken in reliance on this instrument.

_____ _____
Participant Signature Date

_____ _____
Spouse, if applicable Date

_____ _____
Participant Printed Name Spouse Printed Name, if applicable

_____ _____
Plan Sponsor Date