



## Waiver of Health Coverage Form

### Medical Plan Waiver Form

**Plan Year June 1, 2025 – May 31, 2026**

**Employee Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Benefit eligibility date:** \_\_\_\_\_

Core Pipe is offering an Opt-Out Credit for any full-time employee that wishes to waive their medical coverage. For anyone currently not enrolled in our medical plan you will receive \$500 per month credit. (Please note this is taxable income). For anyone that is currently on the plan but wants to waive coverage you will receive \$500 per month for employees only coverage or \$1,000 per month for employee and spouse, employee and children or family coverage.

You must show proof that you have other coverage to receive the incentive payment.

Some things to consider before waiving coverage:

- Can you get coverage elsewhere? – waiving coverage now does not qualify as a life changing event to go to the Market Place or to be added to a spouse's plan unless they are also in open enrollment period.
- Most employers have a plan that has a January renewal so if your spouse's plan is a January renewal make sure you can join their plan.

If you are Medicare eligible (over the age of 65) you can enroll in Medicare at any time as long as you have creditable health and prescription coverage (Core Pipe's plan is creditable).

\_\_\_\_\_ I waive coverage through Core Pipe's group health plan for the plan year beginning on June 1, 2025, and ending on May 31, 2026. This waiver applies to me and my eligible dependents.

I am declining to enroll for the reasons shown below:

\_\_\_\_\_ Covered by spouse's (or domestic partner's) group coverage.

Carrier name/member ID: \_\_\_\_\_

Effective date of coverage: \_\_\_\_\_

\_\_\_\_\_ Enrolled in other group health insurance coverage.

Carrier name/member ID: \_\_\_\_\_

Effective date of coverage: \_\_\_\_\_

\_\_\_\_\_ Enrolled in Medicare – effective date of coverage: \_\_\_\_\_

\_\_\_\_\_ Other (please explain) \_\_\_\_\_

**Attach copy of ID card(s)**

I understand that, by declining/waiving health coverage through Core Pipe, I authorize participation in the Core Pipe Company Section 125 Cafeteria Plan. By waiving the health coverage for the plan year designated above, I acknowledge that I may be required to wait until the next plan year to enroll for group health coverage. In exchange for my waiver of health coverage, Core Pipe will pay me \$115.39 per pay period for single coverage or \$230.77 for more than one per pay period (52 pay periods per plan year) for the plan year of June 1, 2025, through May 31, 2026, for a total annual deposit of \$6,000 for single coverage or \$12,000 for more than one. I understand that these payments are taxable compensation.

**Employee Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**President Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_