



ATTESTATION OF ENROLLMENT IN A NON-EMPLOYER GROUP HEALTH PLAN



Employee Name: _____ Work Phone: _____

Work Location: _____ Email: _____

This form applies to individuals who participate in CompleteCare and who waive coverage in the REEP health plan.

Employees, spouse/domestic partner, and eligible dependents who are waiving coverage in the REEP health plan certify that:

- REEP has offered me and/or my spouse/domestic partner and/or my eligible dependents a group health plan that does not consist solely of “excepted benefits” under the Affordable Care Act of 2010 (“ACA”).
- I and/or my spouse/domestic partner and/or my eligible dependents are enrolled in alternate coverage (such as my spouse/domestic partner’s employer) that does not consist solely of “excepted benefits” under the ACA (such as limited-scope dental or vision coverage), nor does it consist solely of a “health reimbursement arrangement” (reimbursement of health care expenses up to a dollar limit), and we are not enrolled in, or have waived contributions to, an HSA – Health Savings Account.
- I understand that by enrolling in CompleteCare, I am waiving participation in the REEP health plan for the following participants:

Name

Name

Name

Name

Attach a separate sheet if space is needed for additional participants

For confirmation that the alternate coverage meets the IRS’s definition of minimum value and does not consist solely of an HRA, please contact the benefits coordinator at the other employer, and ensure HSA contributions are waived/stopped.

I further certify that my alternate coverage is not:

- A High Deductible Health Plan (HDHP) **with** active contributions to a health savings account (HSA); however, **it is acceptable alternate coverage** if HSA contributions can be waived/discontinued. A spouse/domestic partner who is not enrolled in CompleteCare may contribute to an HSA and use the HSA funds.
- The HSA funds CANNOT be used for medical expenses for CompleteCare enrollees.
- Medicare, Tricare, VA health care or Medicaid
- Health Insurance coverage made available thru the Affordable Care Act
- An individual policy
- A Limited Benefit Health Plan
- Coverage through another REEP employee

Employee Signature:

Date

Spouse/Domestic Partner Signature ONLY IF ELIGIBLE FOR CompleteCare

Date

PLEASE COMPLETE THIS FORM AND SEND TO CATILIZE HEALTH® VIA FAX, EMAIL OR MAIL



2605 Nicholson Road, Suite 1140

Sewickley, PA.15143



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<https://britehr.app/REEP>

Phone: 877-872-4232

Toll Free Fax: 877-599-3724

Memberservices@catilizehealth.com

Hours: 8.30am-8.00pm EST