EATON
REGIONAL EDUCATION SERVICE AGENCY

Human Resources

Cash-In-Lieu-Of Election

(Cafeteria Plan Waiver of Health Insurance)

SECTION I – EMPLOYEE INFORMATION

Name (Last, First, Middle Initial)	Role/Title	Effective Date Requested

SECTION II – INTRODUCTION

I, the undersigned, am an Employee of the Eaton Regional Education Service Agency. In accordance with the terms of my employment with the Employer, and the Eaton RESA Cafeteria Plan (the "Plan"), I have elected to waive coverage for myself and everyone in my "expected tax family" under all major medical insurance programs of the Employer. For purposes of this waiver, my "expected tax family" means all other individuals for whom I reasonably expect to claim a personal exemption deduction on my federal income tax return for the taxable year or years that begin or end in or with the Plan Year to which this waiver election applies. **My waiver is knowing and voluntary and conditioned upon my attesting and providing proof, to the Employer's satisfaction, that I and all members of my expected tax family have enrolled in alternative group health coverage that provides minimum essential coverage as defined under the Affordable Care Act.** Under the terms of the Plan, the terms of my employment, and this Agreement, the Employer is willing to permit me to waive health insurance coverage under the Employer's health insurance program.

SECTION III – ATTESTATION & PROOF OF ALTERNATE COVERAGE

As a condition to my ability to take advantage of this Benefit, by my signing this form I hereby attest that I and the members of my expected tax family are enrolled in alternative group medical coverage, as follows:

Name of Each Member of Your Expected Tax Family (Dependents Covered)	Sponsor of Alternate Group Health Coverage for Each Person	Insurance Carrier Providing the Alternate Group Health Coverage

As proof of my alternative medical coverage, I have attached either (i) a copy of an insurance card issued by the insurance carrier providing the coverage, which must include the covered person(s) name(s), the effective date of coverage and the name of the insurer, or (ii) other satisfactory written confirmation of coverage provided by the insurance carrier or the third-party administrator of the group health plan.

SECTION IV – WAIVER OF PARTICIPATION

In accordance with the Plan, I, for myself and my heirs, assigns, successors, spouse and dependents listed herein, hereby waive any right on our part to participate in any and all major medical insurance programs maintained by the Employer. Other insurance benefits that may be available to me notwithstanding this waiver, including dental, vision, life, and long-term disability insurance, will not be waived. In making this knowing and voluntary waiver, I, on behalf of myself and the members of my expected tax family, understand and agree that we will have no coverage or benefits whatsoever under any of the Employer's major medical insurance programs, and that this waiver may not be revoked, except to the extent permitted under the Plan. My waiver is effective only for the first Plan Year after the date of this Waiver (or within which this Waiver is executed if the signing person has become eligible to participate in the Plan on a date other than the first day of a Plan Year). If my spouse is an Employee of the Employer, this Waiver does not affect my spouse's right to receive Benefits under the Plan, in accordance with the terms of my spouse's employment with the Employer.

SECTION V – RELEASE & INDEMNIFICATION

I, for myself and my heirs, assigns, successors, spouse and dependents listed herein, covenant and agree that I will not make any claim under any of the Employer's major medical insurance programs for medical expenses that I incur during the Plan Year that this Waiver is in effect (even if I receive bills for those expenses after the end of the Plan Year), and I fully release the Employer, the Administrator, and all agents of each of them, and all insurers under policies maintained by the Employer from providing me major medical insurance coverage during the Plan Year, from any liability arising in connection with any claim by me, or my spouse or dependents during the Plan Year, or for any benefits or coverage during the Plan Year under any of the Employer's major medical insurance programs; and I, for myself and my heirs, assigns, successors, spouse and dependents listed herein, agree to defend and indemnify the Employer, the Administrator, and all agents of each of them, from any liability, loss, damages, costs or expenses (including but not limited to attorney's fees) arising in connection with this Agreement, or any claim for benefits or coverage under any of the Employer's major medical insurance programs.

SECTION VI – ACKNOWLEDGEMENTS

Except in the case of an event giving me the right to make a permitted election change, as described in the Plan, I acknowledge and agree that my election to enter into this Agreement and waive coverage under the Employer's major insurance programs is: (i) irrevocable during the Plan Year for which it is made; (ii) knowing and voluntary; and (iii) with full understanding of all the provisions of this Agreement.

SECTION VII – TAX CONSEQUENCES

No representations have been made to me by the Employer as to any possible tax consequences of this Agreement and the Employer shall have no liability with regard to any such tax consequences. I am not relying on the Employer for any tax advice.

SECTION VII – APPLICABLE LAW

This Agreement will be construed in accordance with the laws of the State of Michigan.

SECTION VII – SIGNATURE

NOTE: The Cash-in-lieu-of Health Benefit is paid on the first two payrolls in each calendar month and is taxable income for the employee.

SIGNATURE: Employee	Date

SECTION VII – RESERVED FOR HR/BUSINESS OFFICE USE

Approved Effective Date:_____

Notes/Comments:

PRINTED: HR/Business Office Representative	**SIGNATURE**: HR/Business Office Representative	Date