EMPLOYEE HEALTH INSURANCE OFFER AND STATUS FORM
Revised 07-01-2016

Employer Name: TOWN OF NORWELL **FEIN**: 04-6001253
Department: TREASURERS OFFICE
Employer Address: 345 MAIN STREET
City | State | ZIP Code: NORWELL, MA 02061

Employer: Fill out this portion

1. Is the Employee Full Time or Part Time?	**Full Time**	☐	**Part Time**	☐		
2. If Full Time (**30+ hours per week**) Is the employee Permanent, Temporary, or Seasonal?	Permanent	☐	Temporary	☐	Seasonal	☐
3. If Part Time, is the employee Permanent, Temporary or Seasonal?	Permanent	☐	Temporary	☐	Seasonal	☐
4. If Part Time, is the employee regularly scheduled to work less than or greater than 20+ hours per week?	Less than 20H	☐	Greater than 20H	☐		
(Note: MGL states employees regularly scheduled to work 20+ hours per week are benefit eligible)						
5. If not regularly scheduled, are the employees hours variable in nature?	Yes	☐	No	☐		
6. **Is the employee Benefit Eligible?**	Yes	☐	No	☐		
7. **Did you Offer employer sponsored health insurance to this employee?**	Yes	☐	No	☐		

Employee: Please fill out this portion

FIRST NAME _____ **DATE OF HIRE:** _____

MIDDLE INITIAL _____ **JOB TITLE:** _____

LAST NAME _____

SUFFIX

1. Did you accept your employer sponsored health insurance? Yes ☐ No ☐ Not Eligible ☐
2. Do you have other health insurance? Yes ☐ No ☐

If YES, are you covered under:

Spouse's Insurance	Y	N	(Circle One)
Parent's Insurance	Y	N	(Circle One)
Are you under age 26?	Y	N	(Circle One)
Student	Y	N	(Circle One)

Other: _____

EMPLOYEE AFFIDAVIT

I hereby affirm, under penalties of perjury, all information provided herein is true to the best of my knowledge. I acknowledge, if eligible, I have been offered affordable health insurance coverage that meets minimum creditable coverage standards through my employer. I also understand that if I do not have health insurance I may be responsible for the full cost of all medical treatment; that I may be subject to penalties under Department of Revenue 830 CMR 111M.00 and M.G.L. c 111M, including interest under M.G.L. c. 62C, §§ 32 – 33 on unpaid penalties under M.G.L. c. 111M, § 2.

I understand I may decline insurance through my employer, even if it is considered affordable under the Affordable Care Act, I will be required to fill out a waiver of insurance. I further understand, having access to affordable employer coverage bars me from getting cost assistance on the health insurance marketplace. Also if I decline employer coverage my tax dependents can't get coverage through the employer or cost assistance on the health insurance marketplace either. I understand my employer will require this form annually.

EMPLOYEE SIGNATURE **DATE**

_____ _____