YOUR LIFE
YOUR CARE
YOUR PEOPLE

PPL MEDICARE ELIGIBLE EMPLOYEE
GROUP HEALTH PLAN BENEFIT WAIVER FORM

Public Partnerships, LLC ("PPL") offers its NY-CDPAP, wage parity eligible, Personal Assistants group health plan coverage. All eligible NY-CDPAP, wage parity eligible, Personal Assistants will be automatically enrolled in PPL's BasicWellness Plan. Employees who are enrolled in Medicare Parts A and B may elect to opt out of the PPL's BasicWellness Plan by completing and uploading this form to PPL@Home within 30 days of first becoming eligible (or by December 1 to renew your waiver for the next year) along with a copy of your Medicare card.

I, _____ (name), wish to decline coverage under the PPL's BasicWellness Plan, and I hereby agree and acknowledge the following (*please initial each*):

_____ [*Initial*] I have been auto-enrolled by PPL under the PPL's BasicWellness Plan.

_____ [*Initial*] I am eligible for and I am enrolled in Medicare Part A and Part B, and I have included a copy of my Medicare card with this form.

_____ [*Initial*] My decision to waive the PPL BasicWellness Plan is made voluntarily, I am not required to opt out, and I am not being provided any additional reward or incentive than what I am otherwise entitled to if I opt out of the plan.

_____ [*Initial*] This waiver is irrevocable until it expires unless I experience a qualifying life event (as defined by federal law) that will allow me to enroll in the group health plan during the plan year (prior to open enrollment) in accordance with plan terms.

_____ [*Initial*] **This waiver expires December 31 of the year in which it is signed. A new waiver form will be required for each additional year I wish to waive coverage.**

By signing this form below, I certify that all information provided in this form is true and complete, this waiver is made voluntarily, and I have read and understand the terms and provisions above.

Signature_____

Printed Full Name_____

Date of Birth_____

Date Signed _____

****Please upload a copy of your Medicare card with this Waiver to PPL@Home within 30 days of first becoming eligible for PPL Group Health Plans (or by December 1 to renew your waiver for the next year).****

PPL Internal Use Only:

Received by: _____ Date Received: _____