2024 Waiver of Health Coverage Form

I, _____, understand that I am entitled to health benefits with Fidelity Bank.
(Print Name)

I acknowledge that Fidelity Bank has offered health benefits meeting the requirements of affordable and minimum essential coverage, as defined by PPACA for the 2024 Plan year (January 1, 2024 – December 31, 2024). However, I do not wish to elect or maintain. Fidelity Bank's health benefits as I, and all my eligible dependents, are enrolled in other group minimum essential coverage.

In addition, I am required to provide proof of existing medical coverage in order to qualify for this incentive. I understand the proof must be submitted along with this signed form or the incentive will not take effect on the qualifying date.

Furthermore, I recognize that individual policies, Medicare coverage, and Tricare coverage do not constitute group coverage, and will not qualify for the opt-out incentive.

Employee Name_____ Date_____
(Sign)

Please return completed Form to:
Fax: (814) 696-3244
Email: Benefitshotline@webberadvisors.com
Mail: Webber Advisors
Fidelity Bank Call Center
PO Box 593
Hollidaysburg, PA 16648

Questions may be directed to:
Webber Advisors
Fidelity Bank Call Center
(800) 326-9850

Must be completed and returned by December 18, 2023