MOUNT HOLYOKE
Department of Human Resources
50 College Street
1 Skinner Hall
South Hadley, MA 01075-1453
tel (413) 538-2503 fax (413) 538-3359

Employee Health Insurance Disclosure Form

You are completing this form because you have declined to participate in Mount Holyoke College's sponsored health insurance plan.

Employee First Name **Middle Initial**

Employee Last Name

Employee Social Security Number

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By signing below I acknowledge that I was offered Health Insurance through Mount Holyoke College and that I have chosen to decline coverage.

I understand that if I do not have health insurance I may be responsible for the full cost of all medical treatment and that I may forfeit all or portion of my Massachusetts personal tax exemption and be subject to other penalties pursuant to the Affordable Care Act.

Employee Signature **Date**