

Louisiana Community & Technical College System
Mandatory Disclosures (New Hires)
Patient Protection and Affordable Care Act

Employee's Name (please print)

Hire Date

Section 1: Employment at Another LCTCS College or Board Office

1. Do you hold an additional position at the LCTCS Board Office or any other LCTCS college?
____ YES ____ NO
2. If Yes, please provide the name(s) of the LCTCS institution(s) and Job title(s)

Institution/College Name	Position/Job title

Section 2: Response to Offer of Health Coverage

Acknowledgement

My signature below acknowledges receipt of the offer of health coverage for myself and eligible dependents based on my employment with the River Parishes Community College , and further certifies my decision reflected below.

1. Do you accept or decline the offer of health coverage? ____ACCEPT ____DECLINE
2. If you DECLINE, please provide or indicate the reason(s)

IMPORTANT NOTE*** you may be subject to an IRS penalty if you do not have insurance*****IMPORTANT NOTE**

	Select one
	I'm covered through spouse, parents, other family member
	I have retiree coverage
	I have coverage through another employer
	I'm not interested
Other	

IMPORTANT NOTE*** GB-01 Form must be completed in addition to this form*****IMPORTANT NOTE**

Employee's Signature

Date

Human Resources Representative

Date