

## SMC 14.28 Voluntary Healthcare Expenditure (EXP) Waiver

This form may be provided to an employee who has declined an employer's offer of a monthly required healthcare expenditure under the Improving Access to Medical Care for Hotel Employees, Seattle Municipal Code (SMC) 14.28. Employees who wish to waive should read this form thoroughly to determine if they are eligible to waive.

Employers and employees with questions about this form can contact the Office of Labor Standards (OLS) at 206-256-5297 or visit the OLS website at <http://www.seattle.gov/laborstandards/ordinances/hotel-employee-protections>.

### ***Part A. INFORMATION FOR EMPLOYERS***

*Employers should review and complete this prior to providing the form to an employee.*

To be valid, all conditions required by SMC 14.28 and Seattle Human Rights Rule 190-250 must be met. This includes, but is not limited to:

- An employee may not be pressured to sign the waiver.
- An employer may not suggest or imply that the employee must be required to sign.
- The waiver form must be completed fully.
- The waiver form may not be altered in any way.
- This form must be provided to the employee in their primary language. This form is available in other languages on the Office of Labor Standards website.

Employer's plan for satisfying the healthcare expenditure for:

Name of Employee (First and Last): \_\_\_\_\_

Y/N	Type of expenditure	Monthly amount
	Payment(s) towards employer-sponsored health insurance	
	Payment(s) towards health savings account	
	Payments towards health reimbursement account	
	Payment toward flexible spending account	
	Other (specify):	
	Ordinary income payments	

Employer Contact: For employees with questions related to the healthcare expenditures

Employer Name	
Employer Address	
Employer Contact Person	
Contact Email and Phone	



Name of Employee (First and Last): \_\_\_\_\_

Seattle law requires this employer to make monthly healthcare expenditures to you or on your behalf. A healthcare expenditure is an amount of money paid by your employer to provide you with access to healthcare services. For example, your employer can:

- Make payments to enroll you in a health insurance program;
- Make payments into a health savings account or health reimbursement account for you; and/or
- Make ordinary income payments to you.

Your employer may choose which way(s) to meet their legal obligations. The amount that an employer pays varies depending on the size of your household. The current amounts are listed on the OLS website.

Under certain circumstances, your employer will be deemed to have satisfied its healthcare expenditure for you even if the employer has not made any payments to or on your behalf. For this to happen, the following must be true:

<ol style="list-style-type: none"><li>1. The employer's plan for paying the expenditure would fully satisfy the amount owed to you.</li><li>2. The employer's plan does not require you to pay over a <b>certain dollar amount</b> (shown below) to gain access to the healthcare expenditure (e.g. premium payments for health insurance).</li><li>3. You voluntarily decline all or part of the employer's plan to pay.</li><li>4. You sign this voluntary waiver.</li></ol>	<p>This <b>certain dollar amount</b> changes each year and is made available before July 1. The amount can be found on the Office of Labor Standards website. Visit <a href="http://seattle.gov/laborstandards/ordinances/hotel-employee-protections/improving-access-to-medical-care-for-hotel-employees-ordinance">seattle.gov/laborstandards/ordinances/hotel-employee-protections/improving-access-to-medical-care-for-hotel-employees-ordinance</a> or scan the QR code below to find the current amount. <i>If your employer requires you to pay more than this amount, your employer must provide the full healthcare expenditure owed to you and you cannot waive your rights to the law's protections.</i></p> 
--	---

**EMPLOYER TO FILL OUT THIS SECTION:**

For the \_\_\_\_\_ calendar year, the **certain dollar amount** is \_\_\_\_\_ per month.  
(current year)

(20% of the adjusted monthly expenditure amount for an employee with no spouse, domestic partner, or dependents)

When will this happen? Typically, this will happen if your employer plans to meet its obligations by making payments to enroll you in a health insurance program.

If you decline any or all your employer's chosen way of paying the expenditure, your employer can request that you waive your right to receive these expenditures by signing this waiver.

If you sign this form, you are telling this employer that it can stop making mandatory healthcare expenditures to you or on your behalf. The waiver is only good for one year. An employer must obtain an updated form each year that you wish to waive your rights.

You can also revoke (cancel) a voluntary waiver during any period of annual open enrollment or due to an event that makes you eligible for health coverage by this employer. This cancellation must be in writing. Sample language that you can use is available on the OLS website.

If you do NOT sign but continue to decline all or part of the healthcare expenditure, your employer does not have to make a healthcare expenditure for you.

If you do NOT sign, but do NOT continue to decline all or part of the healthcare expenditure, your employer must make a health care expenditure for you.

### **EMPLOYEE VOLUNTARY WAIVER**

*Sign only if you wish to give up your rights.*

Name of Employee (First and Last): \_\_\_\_\_

By signing below, I certify under penalty of perjury under the laws of the State of Washington that the following is true:

- I read and understand the above information about my rights under the law.
- I decline all or part of the healthcare expenditure my employer has chosen for me, which is listed in Part A of this form.
- I wish to give up my right to receive healthcare expenditures from this employer.
- I understand that this waiver is good for one year.
- I understand that I may cancel the waiver in writing.
- If I have questions, I may contact the employer contact person listed in Part A of this form.

Employee Name		
Signature		
Date		Location (City, State)