ATTESTATION OF ENROLLMENT
IN A NON- AUSTAL, USA, LLC EMPLOYER GROUP HEALTH PLAN

Employee Name:_____ Work Phone: _____

Work Location: _____ Email: _____

This form applies to individuals who participate in the MERP and who waive coverage in the AUSTAL health plan.

Employees, spouses, and eligible dependents who are waiving coverage in the Austal health plan certify that:

-- Austal has offered me and/or my spouse and/or my eligible dependents a group health plan that does not consist solely of "excepted benefits" under the Affordable Care Act of 2010 ("ACA").

-- I and/or my spouse and/or my eligible dependents are enrolled in alternate coverage (such as my spouse's employer) that does not consist solely of "excepted benefits" under the ACA (such as limited-scope dental or vision coverage), nor does it consist solely of a "health reimbursement arrangement" (reimbursement of health care expenses up to a dollar limit).

-- I understand that by enrolling in this MERP, I am waiving participation in the Austal health plan for the following participants:

_____ _____
Name Name

_____ _____
Name Name

Attach a separate sheet if space is needed for additional participants

For confirmation that the alternate coverage meets the IRS's definition of minimum value and does not consist solely of an HRA, please contact the benefits coordinator at the other employer.

I further certify that my alternate coverage is not:

- A High Deductible Health Plan (HDHP) **with** active contributions to a health savings account (HSA); however, **it is acceptable alternate coverage** if contributions can be waived. A spouse who is not enrolled in the MERP may contribute to an HSA and use the HSA funds.
- The HSA funds CANNOT be used for medical expenses for members enrolled in the MERP.
- Medicare, Tricare, VA health care or Medicaid
- Health Insurance coverage made available thru the Affordable Care Act
- An individual policy
- A Limited Benefit Health Plan
- Coverage through another Austal employee

_____ _____
Employee Signature Date

_____ _____
Spouse's Signature ONLY IF ELIGIBLE FOR MERP Date

For more information, please contact Catilize Health @ 877-872-4232

PLEASE COMPLETE THIS FORM AND SEND TO AUSTAL VIA EMAIL OR MAIL:

Sheryl Wainwright
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Sheryl.wainwright@austalusa.com