DECLINATION OF MEDICAL COVERAGE FORM

Microchip Technology Incorporated

Employee Name (*last name, first name, middle initial*) PLEASE PRINT

Badge Number

Your group health plan requires each individual who declines coverage for him/herself or his/her dependent(s) to complete and sign this form. Please read this form carefully.

I am declining to enroll for the following coverage(s) under my employer's health benefits plan:

_____ Employee _____ Spouse Only

_____ Spouse & Child(ren) _____ Child(ren) Only

If you are declining enrollment for yourself or your dependent(s) (including your spouse) because of other health insurance coverage or group health plan coverage, you may in the future be able to enroll yourself or your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' eligibility for other coverage ends. In addition, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after a marriage, birth, adoption or placement for adoption.

I am presently declining medical coverage for the individuals checked above.

Check one:

☐ I (we) have other medical coverage. Name of my (our) other carrier(s):

_____

My plan or group number is: _____

☐ I (we) do not have other medical coverage.

I have read the above and acknowledge that I have been given the opportunity to enroll myself and (if applicable) my eligible dependents. I also acknowledge receipt of this Notice.

By waiving this coverage, you acknowledge that the Employer has offered "affordable minimum essential coverage", as defined under the ACA. By waiving you acknowledge that you have read the above and understand the consequences of your waiver of coverage.

_____ _____

Employee Signature Date