Health Benefits Waiver

Name: _____

Work Site: _____

I acknowledge that my employer has explained the available medical insurance coverages to me and I know that I have every right to apply for coverage. I have been given the opportunity to apply for this coverage and I have decided not to enroll myself and/or my dependent(s), if any.

- **I am also aware that the medical plans offered to me meet the Affordable Care Act (ACA) actuarial minimum value requirements of 60% or greater.**

- **I am also aware that my required contribution toward the cost of single coverage in the lowest cost plan offered, that meets the minimum value test, does not exceed 9.5% of my W-2 income with the District.**

- **I further understand that if I am waiving coverage to participate in the State or Federal Exchange such as Covered California, I am not eligible for any cash in lieu benefits or any district contribution for medical insurance coverage.**

I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to decline coverage.

My signature below affirms that I have current health insurance coverage from another source outside of the District, and I have provided proof of coverage. It is my responsibility to notify the District of any changes within 30 days.

I wish to waive the following health and welfare benefits offered:

Please initial: _____ Medical

By declining this group medical coverage (unless employee and/or dependents have group medical coverage elsewhere). I acknowledge that my dependents and I may have to wait up to twelve (12) months to be enrolled in this group medical unless I have a qualifying event that meets my employer's eligibility requirement.

_____ _____

Employee's Signature Date

Verification of Medical Insurance Coverage **MUST BE** attached.

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****District Use Only****

_____ _____

Proof of Coverage Verified by Date

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