2021-22 SCHOOL YEAR
WAIVER OF GROUP HEALTH BENEFITS

Employee Name

Job Title

Employee Number (ID, Social Security, etc.)

For the plan year effective July 1, 2021, I am waiving coverage for:

☐ Myself

☐ Spouse

☐ Dependents(s):

If selecting Dependent(s), please list their name(s):

I am waiving coverage due to:

☐ Coverage under my spouse's/domestic partner's plan

☐ Other coverage (Please list)_____

This other coverage is:

☐ Employer-sponsored Group Plan ☐ Individual policy ☐Medicare ☐ COBRA ☐TRICARE ☐ Medicaid ☐ Forward Health

☐ Parent/Guardian's plan (under 26 years old)

Special Enrollment Notice and Certification – *Please review and sign below if you wish to waive coverage*

By signing below, I certify that I have been given an opportunity to apply for coverage for myself and my eligible dependents, if any. I am declining enrollment as indicated above. I understand that, if I am declining enrollment for myself or my eligible dependents (including my spouse) because of other health insurance or group health plan coverage, I may be able to enroll myself and my eligible dependents in this plan if I lose, or my eligible dependents lose, eligibility for that other coverage (or if the employer stops contributing towards my or my eligible dependents' other coverage).

I understand that I must request enrollment no more than 30 days after the date the other health plan coverage ends (or after the employer stops contributing toward the other coverage). If I do not do so, I will not be able to enroll until my employer's next annual open enrollment period.

In addition, I understand that if I have a newly eligible dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my eligible dependent(s). However, I must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

I understand that in order to request special enrollment or obtain more information, I should contact my group administrator.

Eligible employees who waive health insurance will receive cash equal to the amount shown on the District's 2020 Option Pro-Ration Grid. Cash-in-lieu is conditioned on an employee's reasonable evidence of enrollment in other employer sponsored health coverage or evidence they will have minimum essential coverage (does not include individual market coverage plans) during the plan year for themselves and their expected tax dependents.

Employee Signature

Date