MT. DIABLO UNIFIED SCHOOL DISTRICT
Human Resources
Benefits Office
(925) 682-8000 x 4152
benefits@mdusd.org

2024 Election of Cash-in-lieu
Waiver of Group Health Insurance

Employee Name: _____ ID #: _____

I elect to waive enrollment in MDUSD's Group Health Insurance. By doing so, I will receive additional, taxable compensation (Cash-in-lieu), the amount to be determined under the applicable collective bargaining agreement / employee contract. Mark the appropriate box below:

- ☐ $171.82/month for CSEA Employees, not to exceed $1890/year
- ☐ $171.82/month for CST Employees (11 months), not to exceed $1890/year
- ☐ $157.50/month for CST Employees (12 months), not to exceed $1890/year
- ☐ $171.82/month for DMA Employees (11 months), not to exceed $1890/year
- ☐ $157.50/month for DMA Employees (12 months), not to exceed $1890/year
- ☐ $171.82/month for MDEA Employees, not to exceed $1890/year
- ☐ $171.82/month for MDSPA Employees, not to exceed $1890/year
- ☐ $171.82/month for 11 month EE for Teamsters/M&O Employees, not to exceed $1890/year
- ☐ $157.50/month for 12 month EE for Teamsters/M&O Employees, not to exceed $1890/year
- ☐ Adult Education/No Bargaining Unit -10 month EE - $174.70, 11 month EE -$158.82, 12 month EE - $145.59, not to exceed $1747/year

To be eligible for Cash-in-lieu, it is my responsibility to provide proof of other qualifying group medical insurance for myself.

Documentation from my spouse's / domestic partner's / parent's employer stating the employee is currently covered under its group health insurance plan will satisfy the proof of qualifying medical coverage.

I acknowledge:

1. My election cannot be changed during the plan year, unless for a qualifying event. See eligibility rules and guidelines.
2. My next opportunity to obtain health insurance coverage will be during the District's Annual Open Enrollment.
3. If I decline coverage, I will not be eligible for COBRA continuation if my employment ends during the period of coverage I have declined.
4. For the Cash-in-lieu benefit to continue from year to year, you must:
    a) complete this annual election form
    b) provide proof of other qualifying group medical insurance
    c) submit (a) and (b) with your Annual Open Enrollment form

Signature: _____ Date: _____