



MT. DIABLO UNIFIED SCHOOL DISTRICT

Human Resources

**Benefits Office**

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**2024-2025 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:

- \$187.27/month for CSEA Employees, not to exceed \$2060/year
- \$187.27/month for CST Employees (11 months), not to exceed \$2060/year
- \$171.67/month for CST Employees (12 months), not to exceed \$2060/year
- \$187.27/month for DMA Employees (11 months), not to exceed \$2060/year
- \$171.67/month for DMA Employees (12 months), not to exceed \$2060/year
- \$187.27/month for MDEA Employees, not to exceed \$2060/year
- \$187.27/month for MDSPA Employees, not to exceed \$2060/year
- \$187.27/month for 11 month EE for Teamsters/M&O Employees, not to exceed \$2060/year
- \$171.67/month for 12 month EE for Teamsters/M&O Employees, not to exceed \$2060/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: \_\_\_\_\_