STATEMENT OF MEDICAL NON-PARTICIPATION

I do not wish to participate in the SDCOE sponsored group health benefit plan. I understand that the premium dollars, which would have been contributed by the SDCOE for my coverage will not be added to my salary. I also understand that unless I qualify under the loss of other coverage provision of HIPAA (see below), I will not have the opportunity to enroll in coverage until a subsequent open enrollment period.

I further understand I am being granted the option to waive my medical coverage due to my enrollment in other coverage. I have attached proof of enrollment in this coverage. I understand my waiver request will not be approved without proof of other medical coverage.

Note: Under a Federal law known as HIPAA, when an employee or a dependent does not enroll due to having other coverage, a special enrollment provision allows an employee/dependent to enroll outside of open enrollment when a loss of other coverage occurs. The appropriate enrollment application must be completed within 31 days following the loss of other coverage. Proof of loss of coverage must also Be received in the form of a COBRA letter or HIPAA certificate.

Employees are urged to give serious consideration to the potential consequences of declining medical coverage.

I agree to the above:

Signature:____ Date: ______________

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