



Chula Vista Elementary School District

EMPLOYEE'S REQUEST FOR WAIVER OF HEALTH INSURANCE COVERAGE

On behalf of myself and my eligible dependent(s) (if any), I waive the option to enroll in a health plan offered at this time by or through the Chula Vista Elementary School District (District) for the following reason:

- _____ I am covered under another group plan as a spouse or dependent
- _____ I am covered by a military plan
- _____ I am covered under another group plan sponsored by a second employer
- _____ I am covered by Medicare, **therefore, I am not eligible for the Waiver incentive**

ALTERNATE COVERAGE

Subscriber Name: _____

Carrier Name: _____ Group/Policy Number: _____

IMPORTANT!

As required, I have attached a copy of my alternate coverage **showing my name as a member**. (Proof of alternate coverage **must** be received by Risk Management before the Waiver of Health Insurance can be approved.) The following documentation is acceptable proof:

- Health plan member I.D. card
- Enrollment/Change form
- Letter from carrier indicating who is cover under the plan

Notice of Enrollment Rights

If you are declining enrollment for yourself and your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself and your eligible dependents in a District-sponsored health plan, provided that you request enrollment within 30 days after your other coverage ends due to a qualifying event. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If your alternate coverage is through another employer, please consult with their benefits department prior to waiving your coverage through the District.

Name of Employee (Please print)

Date

Employee's Signature

Employee I.D. Number

For Risk Management's use:

☐ Copy of alternate coverage received

Effective Date of Waiver: _____