EMPLOYEE BENEFITS - DECLINATION OF COVERAGE

SIG Waiver Form

Last Name: _____ **First Name:** _____ **SSN:** _____ **DOB:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

District: _____ **Bargaining Group:** _____ **Date of Hire:** _____

Eff Date:_____ **Employee ID#** _____ ☐ **Full Time** ☐ **Part Time** **Monthly Payroll Frequency:** ☐ **10** ☐ **11** ☐ **12**

Please read and complete this form if any coverage is declined or refused by an eligible employee and their eligible family members:

Employee Benefits Eligibility with Schools Insurance Group:

All regular full-time employees working 20 or more hours per week. Check with your school district for effective date.

Eligible Dependents include:

- Your legal spouse
- Your registered domestic partner
- Your children until age 26
- Your registered domestic partner's children until age 26
- Your dependent child who is incapable of self-support because of a mental or physical disability

Your benefit elections or declination of coverage remains in effective until Schools Insurance Group's next Open Enrollment unless you have a qualifying life event as defined by the IRS:

- The addition of a dependent through birth, adoption or marriage
- The loss of a dependent through divorce or death, or if your child reaches the maximum age limit for coverage
- A change in eligibility due to your or your spouse's change in employment status
- A substantial change in your benefits coverage or a spouse's coverage
- The addition or separation of a registered domestic partner
- Change in eligibility for Medicaid or Children's Health Insurance Program (CHIP) subsidy (must contact Human Resources within 60 days)

If you experience a family status change and want to change your benefits, you MUST contact Human Resources within 30 days of the change.

If you decline enrollment for yourself or your dependent (including your spouse) because of other health insurance coverage and that coverage ends, you may be able to enroll yourself or your dependents in this plan outside of Open Enrollment. In order to exercise this option, you must request enrollment during the first 30 days after your other coverage ends.

(Please complete next page)

Declining Coverage For:

Myself ☐ **Medical** ☐ **Dental** ☐ **Vision**

Spouse ☐ **Medical** ☐ **Dental** ☐ **Vision**

Children ☐ **Medical** ☐ **Dental** ☐ **Vision**

I decline coverage in the indicated plans noted above for the following dependents:

Spouse Name: _____

Child Name: _____

Child Name: _____

Child Name: _____

Reason for Declining Health Coverage (Required):

- ❑ **Covered by spouse's group coverage.**
  Insurance Carrier:
  _____
- ❑ **Covered by parent's group coverage**.
  Insurance Carrier:
  _____
- ❑ **Covered by an individual Health plan.**
  Insurance Carrier:
  _____
- ❑ **Covered by Medicare**
  Medicare Eligibility Date:
  _____
- ❑ **Other:**
  _____

I acknowledge that the available coverages have been explained to me by my employer, and I know that I have every right to apply for coverage. I have been given the chance to apply for this coverage and I have decided not to enroll myself and/or my dependent(s), if any, and understand that evidence of insurability may be required should I choose to apply for coverage at a later date. I have made this decision voluntarily and understand that I will not be eligible to enroll until next open enrollment or experience a life event.

Effective January 1, 2020, I understand that in response to the elimination of the federal ACA individual mandate penalty, the California legislature enacted the Minimum Essential Coverage Individual Mandate requiring each California resident to generally insure that individuals, their spouses, and dependents are enrolled in minimum essential coverage or pay a penalty. Your employer offers a medical plan that meets the minimum essential coverage therefore this plan is a qualified plan meeting the mandate requirements. By declining my employer's coverage, I will be assuming responsibility in obtaining qualified medical coverage or be subject to penalties when I file my state income tax return.

If I acquire a new dependent as the result of marriage, birth, adoption or placement for adoption, I acknowledge that I, and any dependents I may have, may request enrollment in my employer's group benefit plan(s) by applying for that coverage within 30 days of the marriage, birth, adoption or placement for adoption.

If I have indicated above that the reason for declining coverage for myself or my dependent(s) is coverage under another employer group benefit plan(s), I acknowledge that, if I or my dependent(s) involuntarily lose coverage under the other employer group benefit plan(s), I must request enrollment for myself and/or my dependent(s) in my employer group benefit plan(s) within 30 days. Otherwise, I understand I may not enroll myself and/or my dependent in my employer's group benefit plan(s) until the earlier or the end of my employer's next open enrollment period or 12 months and that "late entrant" provisions may apply.

x_____ _____ _____

Employee Signature **Employee Name - PRINT** **Date**