



PERRIS UNION HIGH SCHOOL DISTRICT

155 East 4th Street

Perris, CA 92570

Telephone: 951.943.6369

DUPLICATE MEDICAL COVERAGE VERIFICATION FORM

EMPLOYEE NAME: _____
(PLEASE PRINT)

EMP ID#: _____ CERTIFICATED: _____ CLASSIFIED: _____

NAME OF INSURANCE: _____

GROUP or POLICY #: _____

INSURANCE GROUP PHONE #: _____

Please include a copy (front & back) of your current medical card.

Full-time employees and employees taking medical benefits with the District are required to have the District's dental and vision insurance coverage. Benefit-eligible employees who provide proof of duplicate medical coverage during the Open Enrollment Process of each fiscal year or within 30 days of their hire date or life event shall be eligible to receive cash in lieu of District medical coverage for that fiscal year. It is the employee's responsibility to inform Risk Management within 30 days of any change of status, i.e., termination of other medical insurance coverage. Employees could be responsible for repaying the District if they are receiving the cash-in-lieu and do not meet the requirements. This form must be completed annually during open enrollment to continue receiving the benefit.

I understand the District has offered me and my eligible dependents medical insurance that provides minimum essential coverage and meets the minimum value standards, and I am electing to waive that coverage. The medical, dental and vision plan summary of benefits and coverage, as well as costs, are located on the district at <https://www.puhsd.org/employee-benefits> and can be viewed at any time. I understand that I have the opportunity to enroll in medical insurance each year during open enrollment, or if I experience a qualifying life event. I will contact benefits@puhsd.org with any questions.

EMPLOYEE SIGNATURE: _____ DATE: _____