CONEJO VALLEY UNIFIED SCHOOL DISTRICT
BUSINESS SERVICES DEPARTMENT
750 Mitchell Road, Newbury Park, CA 91320

HEALTH BENEFIT GROUP COVERAGE—OPT OUT / WAIVER

Employee Legal Name _____ _____ _____
LAST FIRST MIDDLE

Job Classification: _____ **Social Security #** XXX –XX- _____

Employee Contact _____ _____
EMAIL PHONE #

DISCLAIMER AND ACKNOWLEDGEMENT

The Conejo Valley Unified School District "District" has offered you the opportunity to enroll yourself and your eligible dependents in CVUSD group sponsored medical plan(s) in compliance with minimum essential coverage (MEC) per the Affordable Care Act (Health Reform).

If you decline coverage at this time of eligibility, you will not be permitted the opportunity to enroll yourself or your eligible dependents in group coverage until the next annual open enrollment period, or unless you experience a qualifying IRS complaint life changing event.

GROUP COVERAGE PLAN	ELECTING OPT OUT AS FOLLOWS—CHECK ALL THAT APPLY
MEDICAL + RX	☐ Self ☐ Spouse / Registered Domestic Partner ☐ Child(ren)
DENTAL	☐ Self ☐ Spouse / Registered Domestic Partner ☐ Child(ren)
VISION	☐ Self ☐ Spouse / Registered Domestic Partner ☐ Child(ren)
GROUP LIFE	☐ Self

BASIS FOR GROUP COVERAGE OPT-OUT

☐ I am covered as a dependent on my spouse's plan and my spouse is an employee of CVUSD:
Spouse Name: _____ Position/Job Class: _____

☐ I am enrolled in another group plan as a dependent:
Relationship to Subscriber: _____ Employer: _____

☐ I am covered by other coverage under a government plan, such as Medicaid ☐ Medicare ☐

CERTIFICATION

I, _____, have read and understand the rights and benefits afforded to me in compliance with Affordable Care Act Minimum Essential Coverage requirements. My decision to opt-out of coverage is made voluntarily with full understanding of implications.

_____ _____
Signature Date

Conejo Valley Unified School District
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