



Health Benefit Waiver

Confirmation of Alternative Group Plan Coverage

Who is eligible to Waive Benefits (check applicable):

- ☐ Active Employees in CSA, UPE, CONF, TCS or Unrepresented groups with other group coverage.
- ☐ Active Employees in SEIU, SCTA, and Teamster members with other group coverage.
- ☐ Retired SCTA members over 65 with Medicare A and/or B, with dual Medicare health coverage.
- ☐ Retired CalSTRS or CalPERS member with other group coverage.

(Please print)

Name: _____
(Last) (First) Middle Initial Date of Birth

Social Security Number _____ Phone: _____
(Area Code)

Current Year: _____ Status: ☐ Active ☐ Retired ☐ PERS ☐ STRS

I currently have alternative coverage in the following group medical plan provided by an employer through December 31 of this year and accordingly elect to waive coverage through Sacramento City Unified School District.

Name of Subscriber Employer of Subscriber

Subscriber's Social Security Number Medical Plan and Group Number

I affirm that the information given above for alternative group medical benefit coverage is a true and valid statement. This confirmation of Alternative Group Plan coverage is only effective if **proof of other coverage is attached**. Such proof of coverage shall be provided in a manner acceptable to Sacramento City Unified School District.

I understand that by completing this waiver, my benefits will remain in this status until I initiate any further changes during open enrollment or if I have a qualifying event. **I also understand that I do not need to complete a new waiver every year during Open Enrollment, to keep my waiver valid.**

If the above referenced medical plan is terminated, for any reason prior to December 31, I shall provide supporting documentation to the Employee Benefits Office within 30 days of termination. The loss of coverage may be a qualifying event allowing enrollment in a District Health Plan, without waiting for an open enrollment period. If I fail to do so within 30 days or the supporting documentation does not constitute a Qualifying Event, I understand that I will not be enrolled into a District health benefit coverage until the next Open Enrollment period.

By waiving my right to active participation in the District insurance plans, I in no way hold the Sacramento City Unified School District responsible for any claims or costs that would otherwise be covered by these plans, and/or any limitation or exclusions that may be placed upon my coverage by these plans if and when I re enroll as a participant. I understand I cannot enroll as a participant in the District insurance plans I have waived until the next Open Enrollment period, unless there is a qualifying event.

My signature below is acknowledgment that I have read and understand the consequences of this waiver. I have had the opportunity to consult with an employee representative or attorney.

Signature

Date

Employee Benefit Office • 5735 47th Avenue • BOX 840B • Sacramento, CA 95824 • 916-643-9432 • 916-399-2071 FAX