



Health Benefit Waiver

Confirmation of Alternative Group Plan Coverage

Who is eligible to Waive Benefits (check applicable):

Active Employees in CSA, UPE or Unrepresented groups in permanent positions with other group coverage.

Active SEIU 6 & 7 \$ and Teamster members with K H U J U R X S coverage.

Retired SCTA members over 65 with Medicare A and/or with dual Medicare health coverage.

Retired CalSTRS

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Social Security

I currently have alternative coverage through 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 Insured

Employer

Insured's Social Security Number

Medical Plan and Group Number

I affirm that the information given above for alternative group medical benefit coverage is true and valid statement.

I understand that this waiver is only effective for one year, currently ending December 31. I also understand that I need to complete a new waiver every year during Open Enrollment, to keep my waiver valid. Unless a completed waiver with proof of coverage is provided by the close of the open enrollment period, I will be automatically enrolled in the least costly medical plan.

If the above referenced medical plan is terminated, for any reason prior to December 31, I shall provide immediate written notification to the Employee Benefits Office within 30 days of termination. The loss of coverage may be a qualifying event allowing enrollment in a CalPERS/District Health Plan, without waiting for an open enrollment period. If I fail to do so within 30 days or the termination does not constitute a Qualifying Event, I shall be solely responsible for obtaining and paying for health benefit coverage until the next Open Enrollment period.

By waiving my right to active participation in the CalPERS/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 reenroll as a participant. I understand I cannot enroll as a participant in the CalPERS/District insurance plans I have waived until the next Open Enrollment period, unless there is a qualifying event.

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.

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

Signature

Date

Employee Benefit Office • 5735 4th Avenue • BOX 840B • Sacramento, CA 95824 • 916-643-9432 • 916-643-9457 FAX