Opt-Out of City Medical Plan Coverage

Employee Attestation

Name (First Middle Last): ____

Department: ____

Daytime telephone number (   ) ____-__________ Email: ______________________

WAIVER OF COVERAGE CONSIDERATIONS

I understand that by signing this form, I am waiving medical plan coverage for myself and my eligible dependents (i.e., individuals reported on my taxes) and that I will not be eligible to enroll in a City medical plan until the next open enrollment period unless I experience a qualifying event (e.g., marriage, change in spouse's employment).

I certify that my dependents and I (for whom I am waiving coverage) are enrolled in other group health coverage that is deemed to be minimum essential coverage*. I understand that if I choose to opt-out from coverage, that any opt-out payment I may be eligible for will be taxable. Additionally, I understand that I can use this compensation for any purpose, but these monies are not intended to reimburse me for an individual plan in the marketplace or a state exchange plan.

I further understand that I will not be able to revoke this waiver and elect coverage until the next open enrollment period, usually held in September/October for coverage effective the first of the following year, unless I:

- Lose coverage either under another group health plan or insurance coverage. If this happens, I generally can enroll myself, and each dependent that loses other coverage. I understand this does not apply if I lose coverage because I fail to pay premiums on a timely basis or if my coverage is terminated for cause.
- Experience a qualifying change in status. Qualifying changes in status include marriage, divorce, a change in my or my spouse's employment status, my spouse's open enrollment, etc. (For more information on qualifying events, call the Human Resources Department.)
- Acquire a new dependent through marriage, birth, adoption or placement for adoption. If I acquire a new dependent, I can enroll myself and each of my new dependents for medical coverage.

To take advantage of a special enrollment period, I must notify Human Resources within 30 days of the qualifying event. Please contact Human Resources with questions at 415-485-3063.

ACKNOWLEDGEMENT:
I certify that I have read and understand the information above. My signature below indicates that I have elected to waive medical coverage through the City of San Rafael benefit program. **I also understand that I must notify the City no later than 30 days if I (or any individuals reported on my taxes) lose other group health coverage.**

______________________________________ ______________________

Employee Signature Date

*The Affordable Care Act (ACA) establishes a minimum value standard of benefits of a health plan. For a qualifying group health plan to meet the ACA's minimum value standards, the plan must cover at least 60% of the total allowed costs of benefits provided under the plan. Employees should inquire with their other group coverage provider to determine if their coverage is deemed to be "minimum essential coverage."