Santa Clara County Office of Education

Waiver of Coverage

If you decline coverage, you and your dependents will not be allowed to enroll until the Open Enrollment Period. Members who enroll during the Open Enrollment Period will become effective October 1 of the same year.

If you are declining coverage for you and your dependent(s) because you and/or your dependents have coverage elsewhere and you subsequently lose coverage, you may enroll yourself or your dependents within 30 calendar days of loss of coverage.

If you have a new dependent as a result of marriage, birth, adoption, placement for adoption, or placed in your home as a result of court ordered custody or guardianship, you may enroll yourself and your dependents, provided you request enrollment within 30 calendar days following the date of this event. You must submit a completed and signed enrollment or change form.

Effective April 1, 2009 loss of coverage under a Medicaid plan, loss of coverage under Children's Health Insurance Program (CHIP) or eligibility to participate in a premium assistance program under Medicaid or CHIP gives rise to special enrollment rights. You must notify the district within 60 calendar days of loss of coverage or becoming eligible for premium assistance. You must submit a completed and signed enrollment or change form along with a copy of the Certificate of Coverage from the "coverage elsewhere" or evidence of loss of coverage elsewhere.

I hereby certify that I have been given the opportunity to participate in benefits available to me through the Santa Clara County Office of Education Benefits plan. After careful consideration, **I have decided not to participate in the following insurance plans and coverage:**

☐ EMPLOYEE: ☐ Medical ☐ Dental ☐ Vision ☐ Life

☐ SPOUSE OR DOMESTIC PARTNER: ☐ Medical ☐ Dental ☐ Vision

☐ DEPENDENT CHILDREN: ☐ Medical ☐ Dental* ☐ Vision*

(*to age 19 or fulltime student to age 25)

REASON FOR DECLINING THIS COVERAGE *(Must be completed)*:

I have other medical insurance coverage ☐ Yes ☐ No

☐ Other ____

I understand I will not be able to enroll in these benefits again until:

______ (initial) I contact an Employee Benefits Specialist and complete the required forms during the open enrollment period.

______ (initial) I lose my other medical insurance coverage or have a qualifying event as described above.

I understand that I am being offered the opportunity to enroll in affordable, comprehensive health insurance coverage through my employment with the Santa Clara County Office of Education. I understand that I am required by law to maintain an acceptable level of health insurance coverage for myself and my dependents.

WAIVER OF COVERAGE AGREEMENT:

I have read and understand the above notification. By signing this form I have agreed to waive my employer-paid benefits. Unless I experience a qualifying event as defined by the IRS, I will not be allowed to enroll in coverage or make changes to my selection until the next open enrollment period for an October 1 effective date.

EMPLOYEE NAME ______________________________ **DATE** ______________________

EMPLOYEE SIGNATURE X ______________________________

TO BE COMPLETED BY SANTA CLARA COUNTY OFFICE HUMAN RESOURCES ONLY			
Medical Insurance	Date Entered	Delta Dental	Date Entered
QCC Updates	Date Entered	Vision	Date Entered