WAIVER OF OFFER OF MEDICAL COVERAGE

RETIREE NAME (Please print or type)	
DEPARTMENT/DIVISION	RETIREE SSN

I fully understand that as a retiree of **San Benito County**

1. I have the opportunity to enroll myself and my eligible dependents who are under age 26 in medical health coverage offered by San Benito County**.**
2. A portion of the premiums will be my responsibility (depending on plan selection), if I choose to enroll in any of San Benito County's medical group plans,
3. I have the right to decline, or waive coverage, for myself or my eligible dependents,
4. If I waive coverage for myself, I cannot get coverage for my dependents under San Benito County's health plan,
5. The decision to waive coverage means that I cannot rejoin the plan unless I provide proof of loss of other non-individual market health coverage (for example, a spouse's employer plan) that has not lapsed when joining.

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RETIREE NAME (Please print or type)	
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To be completed by Retiree

I attest that I was offered medical coverage have decided to waive coverage. I understand that if I waive coverage, I will not be able to rejoin the County plan unless I provide proof of loss of other non-individual market health coverage that has not lapsed.

I have read the above and I understand the consequences of my waiver of coverage.

Signature: _____ **Date:** _____

Plan Information
For updated plan information, please visit the Human Resources' Benefits page on the County website, or contact Human Resources.

Completed enrollment or waiver forms must be received by Human Resources no later than 31 days after your date of retirement or qualifying life event.