WAIVER OF OFFER OF MEDICAL COVERAGE

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

In accordance with the Patient Protection and Affordable Care Act (ACA) of 2010, you and your qualified dependents are eligible to enroll in your choice of the County's group Kaiser HMO, Anthem Choice PPO, Anthem Safety PPO and Anthem HDHP medical plans.

I fully understand that as an employee of **San Benito County**

1. I have the opportunity to enroll myself and my dependent children 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), through payroll deduction, 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 dependent children,
4. If I waive coverage for myself, I cannot get coverage for my dependent children under San Benito County's health plan,
5. The decision to waive coverage means that:
    - I could be subject to a penalty under the individual responsibility requirement of the Affordable Care Act (ACA).
    - I cannot enroll in San Benito County's medical plans unless I experience a qualified change in status. Examples include if I was covered under another group medical plan but that coverage is lost, or if I gain a new dependent through birth or adoption.
    - I must submit proof of other, non-individual market health coverage (for example, a spouse's employer plan) for myself and tax dependents to waive coverage in order to be eligible for any cash waiver benefit.

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To be completed by Employee

I attest that I was offered affordable, minimum value health coverage, as defined under the ACA, through San Benito County for the period from _____ to _____ and have decided to waive coverage.

I understand that in order to be eligible for the County cash waiver, I cannot waive health insurance for myself and/or tax dependents without proof of other, non-individual market health coverage.

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

Signature: _____ **Date:** _____

Plan Information

An enrollment form can be obtained by contacting Human Resources. 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 hire or qualifying life event.