



## 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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### **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.