WAIVER OF COVERAGE FORM
City of Garden Grove

PERSONAL INFORMATION

Name: _____ Employee Number:_____

WAIVER OF COVERAGE CONSIDERATIONS

I understand that by signing this form, I am waiving coverage for myself and my eligible tax dependents and that I will not be eligible to enroll in the benefit program selected below until the next open enrollment period unless I experience a family status change (check all that apply):

☐ Medical
☐ Dental
☐ Vision

I certify that my tax 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 the opt-out incentive 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 **fall** 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 changes in status, 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 and/or dental coverage.

To take advantage of a special enrollment period, I must request to enroll within 30 days of the specified event.

If you elect Medicare please know that waiving the employer plan can affect your Medicare coverage. For example, if you reject the plan, the plan will not be permitted to provide or pay for secondary benefits. Please contact your legal counsel or tax advisor for additional information as to how waiving coverage can impact your Medicare rights.

If you waive coverage, proof of other coverage must be returned with this waiver form for yourself and all eligible tax dependents or your cash waiver may be withheld until proof of other coverage is provided.

SIGNATURE
I certify that I have read and understand the information above. My signature below indicates that I have elected to waive medical, dental and/or vision coverage through the City's benefit program.

_____ _____

Employee Signature Date