BENEFITS PROGRAM FOR CITY OF MILPITAS – MEDICAL WAIVER FORM

SECTION I: PERSONAL INFORMATION				
LAST NAME (PRINT)	FIRST NAME (PRINT)	MI	1 ☐ MALE 2 ☐ FEMALE	SOCIAL SECURITY NO.
STREET ADDRESS	CITY	STATE	ZIP	
TELEPHONE NO.	DATE OF BIRTH (MM/DD/YYYY)	DATE OF HIRE/CHANGE	JOB TITLE/CLASSIFICATION	EFFECTIVE DATE
EMAIL ADDRESS				

SECTION II: WAIVING COVERAGE/CASH IN LIEU

DECLINATION OF COVERAGE: The available medical coverage has been explained to me by my employer. I have been given the chance to apply for the available medical coverage. I have decided not to enroll myself and/or my eligible dependents. I am covered as an eligible dependent under the insurance described below.

In consideration of this waiver, I understand the City will give "$125 cash" in lieu of health insurance per month unless specified otherwise. This amount is pro-rated for part time employees on their budgeted hours. I understand that if I fail to provide proof of continued health care coverage during the annual open enrollment period, "125 cash" in lieu of health insurance per month will be discontinued. *Note: Participation in the Health Waiver Program is a yearly election unless one of the following changes occurs: marriage, loss of spouse's health insurance coverage due to termination of employment, death, or divorce. If you lose health insurance coverage for other than the reasons above, you may petition for admittance into one of the City's health plans. However, the final decision as to whether you will be admitted rest with the health plan.*

By declining coverage I acknowledge that my dependents and I may have to wait to be enrolled until the next Open Enrollment period or qualifying event.

I am declining medical coverage for myself and all of my dependents:

Reason for Declining Coverage:

☐ Enrolled in other medical coverage

Please provide the following information:

Subscriber Name:______________________________________ Relationship to employee:_____________________________

Subscriber's Employer:__________________________________ Employer's Address:__________________________________

Name of Insurance Plan:_________________________________ Group No:____

ID No:____ SS No:____

I authorize the release of information to the City of Milpitas to confirm or deny this health insurance coverage available to _______________________ (employee name) as a result of my employment.

I will provide a copy of my Health Insurance Card when returning this form.

Subscriber's Signature:______________________________ Date:____________________________________

SECTION III: ACKNOWLEGEMENT OF QUALIFIED CHANGES

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 immediately provided you notify the City within 30 days of loss of coverage. 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 City within 60 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.

In addition, 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 days following the date of this event. Again, you must submit a completed and signed enrollment or change form.

If you fail to notify your employer that your dependent(s) is no longer eligible for coverage under your plan, they may not be eligible for continuation coverage under the COBRA or CalCOBRA laws.

I have read and understand the above notification. I understand that, if I decline coverage, I will be not be able to enroll in coverage until the City's Open Enrollment period for a January 1 effective date or because of one or more of the events listed above.

By signing below I certify that the reason I am declining coverage is accurate as indicated by the check marks above. In the event of any discrepancy between this document and any coverage policy, the terms of the policy prevail. Complete coverage information is contained in the certificate of insurance booklet issued to each insured individual.

Employee Signature:____ Date: ________________________

Return your completed form to the City of Milpitas Human Resources
455 East Calaveras Boulevard Phone: (408) 586-3090

(Rev 1/14)