



**AMADOR COUNTY OFFICE OF EDUCATION
AMADOR COUNTY UNIFIED SCHOOL DISTRICT**

BUSINESS SERVICES DIVISION
217 Rex Avenue – Jackson, CA 95642
FAX (209) 223-1733

Waiver of Group Health Benefits & Notice of Special Enrollment Rights

Please complete the following:

Employee Name: _____
Last Name First Name MI

Employee Number: _____
Social Security or Employee ID number

I am waiving coverage for:

- Myself
- Spouse/Domestic Partner
- Child (ren) –

Please list names: _____

Please check coverage you are waiving:

- Medical

I am waiving coverage due to:

- My preference not to have coverage
- Coverage under my spouse's/domestic partners plan – name of carrier: _____
- Other Coverage – name of carrier: _____

This other coverage is: Individual COBRA Medicare Medicaid
 TRICARE (formerly CHAMPUS)
 Employer-Sponsored Group Plan

Please review and sign below if you wish to waive coverage.

By signing below, I certify that I have been given an opportunity to apply for coverage for myself and my eligible dependents, if any. I am declining enrollment as indicated above. I understand that I am declining enrollment for myself or my eligible dependents (including my spouse) because of other health insurance or group health plan coverage, I may be able to enroll myself and my eligible dependents in this plan if I lose, or my eligible dependents lose, eligibility for that other coverage (or if the employer stops contributing towards my or my eligible dependents' other coverage).

I understand that I must request enrollment no more than 30 days after the date the other health plan coverage ends (or after the employer stops contributing towards the other coverage). If I do not do so, I will not be able to enroll until my employer's next annual open enrollment period.

In addition, I understand that if I have a newly eligible dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my eligible dependent(s). However, I must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

I understand that in order to request special enrollment or obtain more information, I should contact my group administrator.

Signature of Employee

Date of Signature