WAIVER OF MEDICAL INSURANCE VERIFICATION OF ELIGIBILITY

PLAN YEAR 2015

_____ _____
Employee Name (Print) Employee ID Number

Complete the following information for individuals for whom you are waiving medical coverage, **including** yourself, if applicable.

NAME	RELATIONSHIP	DATE OF BIRTH
	Self	
	Spouse/ Domestic Partner	
	Dependent	
	Dependent	
	Dependent	

OTHER COVERAGE:

Policyholder's Name_____ Policyholder's Phone Number_____

Name of Policyholder's Employer_____Employer's Phone No._____

Name of Other Insurance Plan_____ Group Policy Number_____

I hereby waive health insurance coverage for myself and/or my eligible dependents for the current plan year. I realize that by waiving coverage, I may not re-enroll either myself and/or my dependents in the City's health insurance until the following plan year. The only exceptions allowed would be those stated on page two of this form, in the Notice of Special Enrollment Rights.

If I am in an employee group which receives a rebate for waiving a level of medical insurance, I understand that participation in the rebate program requires current eligibility. If my dependents become ineligible under the City's health plan (through divorce, dependent maximum age limit, marriage, etc.) during the time I am being paid this rebate, I will notify the Human Resources Benefits Division immediately. If eligibility for rebate ends, I would forego any further rebates and understand overpayments must be repaid in full to the City. I authorize automatic repayment to the City through payroll deduction for any rebates received for any period later determined ineligible. I understand that I must apply each plan year for this rebate, and if I fail to do so during the annual open enrollment period, I will be automatically ineligible for rebates the following calendar year.

I have read and understand this waiver form, including the Notice of Special Enrollment Rights and Loss of Dependent Eligibility on page two. I understand that by signing this form, I am attesting that I and/or my family members, for whom I am waiving coverage, are currently covered under another health insurance plan. If this is my first time participating in this waiver program, I have attached a proof of alternate coverage. (Copy of insurance ID card for other plan.) The City reserves the right, at any time, to request additional current proof of alternate coverage.

_____ _____
Employee's Signature Spouse's Signature

_____ _____
Date Date

REBATE ELIGIBILITY RESTRICTIONS

A domestic partner eligible under this rebate program must be a registered domestic partner through the State of California or other recognized Municipal or State governmental law.

If you and your spouse (or registered domestic partner) are both employed by the City of Escondido, the City rule allows for only one party to request and receive the monthly rebate for waiving their health insurance coverage.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in one of the City's plans if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependent's other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing towards the other coverage). If mid-year enrollment is requested due to loss of other coverage, you will be required to provide proof of loss of coverage through the other health plan in order to enroll on the City's plan.

In addition, you may be able to enroll yourself and your dependents on your benefit plans mid-year under a family status change that would include:

- Your marriage
- Birth, adoption or placement for adoption of an eligible child
- State registration of a domestic partner
- A change in your child's eligibility for benefits
- Change in address that affects eligibility for coverage
- A significant change in your or your spouse's health coverage or cost of benefit
- Receiving a Qualified Medical Child Support Order (QMCSO)

However, you must request enrollment within 30 days after the event triggering the newly eligible dependent. To request special enrollment, contact the City's Human Resources Benefits Division. The City may request documentation for proof of newly eligible dependents.

A special enrollment opportunity may be available in the future if you or your dependents lose other coverage. This special enrollment opportunity will not be available when other coverage ends, however, unless you already have on file with the City's Benefits Division, this completed "Waiver of Medical Insurance Verification of Eligibility" form indicating you are declining coverage for yourself or your dependent(s). Failing to accurately complete and return this form for each person for whom you are declining coverage will eliminate this special enrollment opportunity for that person(s), even if other coverage is currently in effect and is later lost. In addition, unless you indicate that you are declining coverage because other coverage is in effect, you will not have this special enrollment opportunity for the person(s) covered by this statement.

Special enrollment rights also exist in the following two circumstances, in which you or your dependents will have sixty (60) days from the date of the eligibility event to request special enrollment in the group health plan coverage:

- If you or your dependents experience a loss of eligibility for Medicaid or your State Children's Health Insurance Program (SCHIP) coverage; or
- If you or your dependents become eligible for premium assistance under an optional state Medicaid or SCHIP program that would pay the employee's portion of the health insurance premium.

LOSS OF DEPENDENT ELIGIBILITY

Generally, you may only change your benefit plan choices during the annual benefits open enrollment period. However, any change that results in a dependent becoming ineligible must be taken care of immediately.

If you have a family status change that results in the loss of eligibility for a covered dependent, you must notify the Human Resources Benefits Division within 30 days of the change. Family status changes resulting in the loss of dependent eligibility include:

- Your divorce, legal separation, or annulment
- Your legal dissolution of a State registered domestic partnership
- Death of your spouse, domestic partner, or covered child
- A change in a child's eligibility for benefits (i.e. marriage, overage, no longer your dependent)

Notifying the Human Resources Benefits Division of a loss of dependent eligibility, within 30 days of the change, protects an eligible dependent's COBRA continuation of medical insurance privilege. It also prevents your liability for any rebates, premiums or claims paid by the City for an ineligible dependent.

If you are unsure whether you have a family status change that affects your benefits, or if you want further clarification of the family status change laws, contact the Human Resources Benefits Division.