OFFICE USE ONLY

- ◯ 2018 CONFIRMATION
- ◯ WAIVER FORM
- ◯ DECLARATION FORM
- ◯ PROOF OF COVERAGE
- ◯ COMPLETE RECEIPT

ORANGE UNIFIED SCHOOL DISTRICT

Risk Management
1401 N. Handy Street - Orange, California 92867
Phone: 714.628.5390 - Fax: 714.628.4186

EMPLOYEE WAIVER OF GROUP HEALTH BENEFITS AND NOTICE OF SPECIAL ENROLLMENT RIGHTS

Employee Name: _____ Employee ID: _____

Work Site: _____ Work Email: _____

Check One: ☐ Certificated ☐ Classified ☐ Leadership

For the plan year effective January 1, 2018, I am waiving coverage for myself and the spouse/dependents listed below:

List spouse, if applicable.	List dependent, if applicable.	List dependent, if applicable.
List dependent, if applicable.	List dependent, if applicable.	List dependent, if applicable.

I am/We are covered for health benefits under one of the following programs:

☐ Spouse's/domestic partner's/parent's employer group plan ☐ Other employer-sponsored group plan

☐ COBRA ☐ Medicare ☐ Medicaid ☐ TRICARE ☐ Other government-sponsored program

Special Enrollment Notice and Certification

By signing below, I certify that I have been given an opportunity to enroll for coverage (including medical, dental, and vision) for myself and my eligible dependents, if any. I understand that I am declining enrollment for myself and my eligible dependents (including my spouse/domestic partner), if any, because of other group health plan coverage or health insurance program. I understand I am retaining my life insurance coverage.

I understand that 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 toward 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 be eligible for compensation for waiving these health benefits, I must submit the American Fidelity Benefit Confirmation form, this Waiver form, Declaration of Health Coverage, and proof of other coverage to the Risk Management Department, for myself and any eligible/expected tax family, no later than Friday, October 27, 2017 or I will not receive $270.00 per month, for ten months for waiving my health benefits.

I understand to request Special Enrollment, I should contact Risk Management at 714.628.5390.

Employee Signature: _____ Date: _____

TURN PAGE OVER

Member Account Management Division
P.O. Box 942715 Sacramento, CA 94229-2715
(888) CalPERS (or **888**-225-7377)
TTY (877) 249-7442
FAX (800) 959-6545

CalPERS

Declaration of Health Coverage: HBD-12A

EMPLOYEE INFORMATION SOCIAL SECURITY NUMBER _____-_____-_____	NAME (FIRST) (MIDDLE) (LAST) _____

PART A ☐ I elect to enroll myself and all eligible dependents.	
PART B-1 ☐ I elect to enroll myself. My eligible dependents have other health insurance coverage.	If you or your dependents lose health insurance coverage, you can enroll in the CalPERS Health Benefits Program. You must request enrollment within 60 days from the date you lose coverage. If you do not request enrollment within 60 days, you or your dependents must wait at least 90 days or until the next Open Enrollment Period before you can enroll in the Program. Your effective date of coverage will be the first of the month following the 90-day waiting period or the Open Enrollment effective date.
PART B-2 ☐ I elect to enroll myself and all eligible dependents. I also have eligible dependents who have other health insurance coverage.	
PART C-1 ☒ I decline enrollment for myself and my eligible dependents because we have other health insurance coverage.	
PART C-2 ☐ I decline enrollment for myself and/or my eligible family members for reasons other than having health insurance coverage.	You can request enrollment for yourself and/or your dependents at any time. You must wait at least 90 days after you request enrollment or until the next Open Enrollment Period before you can enroll in the Program. Your effective date of coverage will be the first of the month following the 90 day waiting period or the Open Enrollment effective date.

PART B: If you are currently enrolled in the Health Benefits Program and you acquire new dependents or if a court orders health coverage for your dependents, you can add your new dependents. See your Health Benefits Officer or visit your personnel office for applicable time limits.

PART C: If you are not currently enrolled in the Health Benefits Program and you acquire new dependents as a result of marriage, birth, adoption, or placement for adoption, or if a court orders healthcoverage for your dependents, you can enroll yourself and dependents. See your Health Benefits Officeror visit your personnel office for applicable time limits.

Special rules apply to retirement and death.

Member's Signature	Date Signed	Health Benefits Officer's Signature