

ORANGE UNIFIED SCHOOL DISTRICT

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

2018 CONFIRMATION
WAIVER FORM
O DECLARATION FORM
PROOF OF COVERAGE
OCOMPLETE RECEIPT

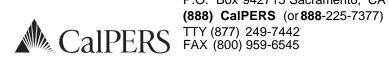
OFFICE USE ONLY

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	t dependent, if applicable.	List dependent, if applicable.		
List dependent, if applicable.	dependent, if applicable.	List dependent, if applicable.		
I am/We are covered for health benefits und	der <mark>one of the following p</mark>	rograms:		
Spouse's/domestic partner's/parent's en	mployer group plan 🔲 O	ther employer-sponsored group plan		
COBRA Medicare Medic	aid 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:				

Member Account Management Division

P.O. Box 942715 Sacramento, CA 94229-2715



Declaration of Health Coverage: HBD-12A

EMPLOYEE INFORMATION SOCIAL SECURITY NUMBER	NAME (FIR	RST) (MIDDLE) (LAST)	
PART A I elect to enroll myself and a dependents.	ll eligible		
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.	
PART B-2 I elect to enroll myself and all eligible dependents. I also have eligible dependents who have other health insurance 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	
PART C-1 I decline enrollment for myse my eligible dependents becannot have other health insurance	ause we	first of the month following the 90-day waiting period or the Open Enrollment effective date.	
PART C-2 I decline enrollment for mys my eligible family members reasons other than having hinsurance coverage.	for	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 a	and death.		
Member's Signature	Date S	-	
Rev 12/15	Origina	nal: Employee's File	