Health Benefits Waiver Form

Employer: North Central Fire Protection District 15850 W. Kearney Blvd., Kerman, CA 93630			
Employee Name:	*Last*	*First*	*Middle Initial*
Employee Social Security Number:			
Date of Employment:			
Date of Birth:			

For the plan year effective _____/_____/_____ I am declining coverage for:

☐ Myself

☐ Spouse/Domestic Partner

☐ Dependent(s) – Please list names: _____

I am declining to enroll for the reason shown below:

☐ Covered under my spouse's/domestic partner/parent plan

Carrier Name and Member ID_____

☐ Enrolled in another Insurance Carrier Plan

Carrier Name and Member ID_____

☐ Covered by Medicare, Medi-Cal, COBRA, Medicaid, TRICARE or CHAMP VA (please circle)

☐ Other *(Please explain)* _____

By signing below, I acknowledge that I have been given the opportunity to enroll in a group insurance health plan for myself and my eligible dependents, if any. I understand that I am declining enrollment for myself or my eligible dependents (including 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 or my eligible dependents lose eligibility for that other coverage.

I understand that I must request enrollment no more than 30 days after the date the other health plan coverage ends. If I do not do so, I will not be able to enroll until the plan's next 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.

_____ _____

Employee Signature Date