Health Benefit Waiver

Confirmation of Alternative Group Plan Coverage

Who is eligible to Waive Benefits (check applicable):

Active Employees in CSA, UPE or dual Medicare health coverage.

Retired CalSTRS or CalPERS members with R W K H U J U R X S F R Y H U D J H

(Please print)

Name: _____ _____ _____ _____
(Last) (First) Middle Initial Date of Birth

_____ Phone: _____ _____
Social Security Number (Area Code)

Current Year: _____ Status † Active † Retired † PERS † STRS

I currently have alternative coverage in the following group medical plan provided by an employer through December 31 of this year and accordingly elect to waive coverage through Sacramento City Unified School District.

_____ _____
Name of Insured Employer

_____ _____
Insured's Social Security Number Medical Plan and Group Number

I affirm that the information given above for alternative group medical benefit coverage is true and valid statement.

I understand that this waiver is only effective for one year, currently ending December 31. I also understand that I need to complete a new waiver every year during Open Enrollment, to keep my waiver valid. Unless a completed waiver with proof of coverage is provided by the close of the open enrollment period, I will be automatically enrolled in the least costly medical plan.

If the above referenced medical plan is terminated, for any reason prior to December 31, I shall provide immediate written notification to the Employee Benefits Office within 30 days of termination. The loss of coverage may be a qualifying event allowing enrollment in a CalPERS/District Health Plan, without waiting for an open enrollment period. If I fail to do so within 30 days or the termination does not constitute a Qualifying Event, I shall be solely responsible for obtaining and paying for health benefit coverage until the next Open Enrollment period.

By waiving my right to active participation in the CalPERS/District insurance plans, I in no way hold the