INSURANCE WAIVER & PROOF OF OTHER COVERAGE

EMPLOYEE NAME: ____________________________________

POSITION: ____

EMPLOYMENT DATE: _________________________________

DEPARTMENT NAME: _________________________________

I. NEWLY APPOINTED EMPLOYEE:

___ I am a new employee of Stanislaus County. I have been offered enrollment in health, dental, vision and supplemental life insurance plans. The terms, conditions, and costs involved in such enrollment have been fully explained to me. I hereby waive enrollment in:

____ Health Plan
____ Dental Plan
____ Vision Plan
____ Supplemental Life Insurance Plans

I have attached copies of proof of my other coverage. I understand that should I lose my other coverage, there are restrictions on when I would be allowed to enroll in the future.

If I do not have proof of dental & vision coverage, I will have to wait until next open enrollment effective date.

____ I have waived the above coverage because my spouse is employed by the County and has covered me as a Dependent. Please specify your spouse's name & department. _______________

II. CURRENT EMPLOYEE:

_____ I am an employee of Stanislaus County and have been enrolled in the following insurance plans:

______ Health Plan
______ Dental Plan
______Vision Plan

I wish to withdraw and/or not elect coverage from the following plans:

____ Health
____ Dental Plan
____ Vision Plan

OVER.....READ AND SIGN OTHER SIDE.......⇩

_____ I have waived the above coverage(s) because my spouse is employed by the County and has covered me as a dependent. Please specify your spouse's name and Department:

____

_____ I have waived the above coverage because I have coverage through another plan. Please specify Plan name and number:

__________________________Health Plan
__________________________Dental Plan
__________________________Vision Plan

I understand that if I can not waive Dental and/or Vision without proof of other coverage until I have been on the plans for at least three (3) years (this includes dependents over the age of 4 years of age). If, after the three (3) year period, I elect to discontinue coverage in either the dental and/or vision plan during open enrollment, I can not re-enroll.

_____ I have been on the above coverage for at least three years and elect to waive my coverage, I understand that I can not re-enroll.

I understand that if I decide to enroll re-enroll in one of these plans at a future date, the terms and conditions may not be the same as if I enrolled now or continued with existing enrollment and under certain situations my re-enrollment may be denied or restricted. See above. The open enrollment will occur once each year and I understand I can only renew available coverage during this period with out proof of other coverage loss and paperwork submitted during 30 days from date of qualifying event.

I understand that I am freely waiving the right to participate in these benefits. Further, I understand that the County shall provide compensation in the manner approved by the Board of Supervisors for employees in my classification, for those benefits that I have not selected.

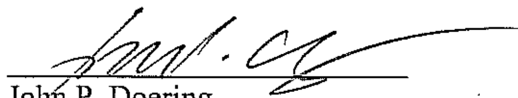
I have had the opportunity to ask questions and understand the consequences of not selecting these benefits. I have read and understand the above terms, conditions and contents of this insurance waiver.

DATED: ________________

Employee Signature: ______________________

Department Representative: _____________________

APPROVED AS TO FORM:



John P. Doering
County Counsel