EL RANCHO UNIFIED SCHOOL DISTRICT
WAIVER FORM FOR 2022

I_____acknowledge that I have been offered to participate in the Group Health Insurance Plan offered by my employer **El Rancho Unified School District** for myself and my eligible dependents. *(If you waive coverage for yourself, you may not enroll your dependents under the Group Health Plan.)*

If you are opting out of Medical Coverage, you must complete the waiver form along with proof of insurance during Open Enrollment. ***If you fail to submit your Waiver Form, your Cash-In-Lieu benefits will be cancelled until the next open enrollment. Waiver Forms that are not completed or missing proof of insurance will not be accepted.***

I am declining to enroll for the reason below:

☐ Spouse is an Employee with El Rancho Unified School District

☐ Covered by spouse's/domestic partner's/ parent's/ group coverage

☐ Enrolled in an individual plan

☐ Enrolled in a government plan

☐ I am not currently covered by any other health plan

☐Other (please explain) :_____

Please Provide Details of Coverage:
Carrier Name: _____
Policy/Contract Number: _____

If you are declining enrollment for yourself and your eligible dependents, you and your dependents will not have coverage until the next open enrollment, unless you experience a qualifying event.

Examples of qualifying events:
*If you involuntarily lost coverage, you may enroll in benefits for yourself and eligible dependents.
*If you have new dependents as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents.
We must receive your completed enrollment forms along with dependent verification within 60 days. If you miss the 60 day enrollment period, you will have a 90 day waiting period or you will need to wait until the next open enrollment.

_____	_____
Signature of Employee (please provide your full name)	**Social Security Number -or- Employee I.D. (please provide the complete number)**

Date:_____