



Medical Waiver Form

Name _____

Employee ID _____

Instructions

To waive the District's medical coverage, you must review below and submit this form along with any other required documents.

Step 1: Review Waiver Reasons and Check Applicable Box

On behalf of myself and eligible dependents (if any), I waive the option to enroll in the Grossmont-Cuyamaca Community College District medical insurance that is offered to me for the 2022 plan year for the following reason:	
<input type="checkbox"/>	I am covered under another group plan as a spouse/domestic partner or dependent
<input type="checkbox"/>	I am covered by a VEBA approved plan through my spouse or domestic partner
<input type="checkbox"/>	I am covered by Medicare or Veterans Program
<input type="checkbox"/>	I have other coverage – name of carrier: _____ <input type="checkbox"/> COBRA <input type="checkbox"/> TRICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> EMPLOYER GROUP PLAN <input type="checkbox"/> OTHER

Step 2: Provide Proof of Other Coverage

Proof of other coverage may include: letter from your spouse's/registered domestic partner's employer showing current coverage, effective date of coverage, list of covered members, copy of your Medicare membership card, and official proof of TRICARE/COBRA/MEDICAID/OTHER coverage.

Step 3: Review Qualifying Events

By declining medical coverage, I understand that I do not have the option to waive dental or vision coverage. The district, at its sole option, may in the future require me to enroll in a district medical plan. Without a qualifying event, I understand that I have the option to enroll during a future open enrollment. To enroll outside of open enrollment, I must have a qualifying event and will notify the district Benefits Department within **30 days** with supporting documentation:

1. Loss of coverage due to termination of employment of spouse/registered domestic partner
2. Change in spouse's/registered domestic partner's employment status (full-time to part-time)
3. Family status change (marriage, birth, adoption, divorce, legal separation, or Qualified Medical Child Support Order)

Step 4: Review, Sign, and Date

I hereby acknowledge I have been given an effective opportunity to enroll in medical coverage offered by Grossmont-Cuyamaca Community College District and the coverage meets the standards of affordable, minimum value coverage as defined by the Affordable Care Act.

I understand that other health coverage cannot include coverage purchased on the individual market, including through Covered California. In addition, I must renew this waiver annually during open enrollment.

I have read, I understand, and I agree to all the information above.

Employee Signature _____

Date _____