CVT WAIVER FORM
EMPLOYEE BENEFITS - DECLINATION OF COVERAGE

Please read and complete this form if you or your dependents are waiving benefits:

All full-time employees (1.00 FTE) are required to participate in benefits.

Eligible Dependents include:

· Your legal spouse (marriage certificate is required)
· Your qualified domestic partner
· Child of an enrolled employee or domestic partner until age 26 (birth certificate required)
· Your permanently disabled child

Your benefit elections or declination of coverage remains in effective until CVT's next Open Enrollment unless you have a qualifying life event as defined below:

- The addition of a dependent through birth, adoption or marriage
- The loss of a dependent through divorce or death, or if your child reaches the maximum age limit for coverage
- Court ordered guardianship of a minor child
- The requirements of domestic partnership are met
- The effective date of a 25% increase in the employer/employee portion of contribution to the benefit package
- The effective date of an increase in the number of hours worked by the employee
- The termination of employment of the person through whom the employee's dependent was previously covered
- A change in the employee's employment status of a change in the employment status of the individual through whom the employee's dependent was previously covered
- The involuntary termination of the other plan under which the employee's dependent was covered
- The cessation of an employer's contribution toward an employee's or dependent's coverage
- acquiring coverage
- gaining Medicare

If you experience a family status change and want to change your benefits, you MUST contact Human Resources within 31 days of the change.

If you decline enrollment for yourself or your dependent (including your spouse) because of other health insurance coverage and that coverage ends, you may be able to enroll yourself or your dependents in this plan outside of Open Enrollment. In order to exercise this option, you must request enrollment during the first 31 days after your other coverage ends.

☐ **Full Time** ☐ **Part Time**

Employee: **Last Name**_____ **First Name**_____

(Please complete next page)

Declining Coverage For:

Myself ☐ **Medical** ☐ **Dental** ☐ **Vision**

Spouse ☐ **Medical** ☐ **Dental** ☐ **Vision**

Children ☐ **Medical** ☐ **Dental** ☐ **Vision**

I decline coverage in the indicated plans noted above for the following dependents:

Spouse Name: _____

Child Name: _____

Child Name: _____

Child Name: _____

Reason for Declining Health Coverage:

- ❑ **Covered by spouse's group coverage.**
  Insurance Carrier:
  _____
- ❑ **Covered by parent's group coverage**.
  Insurance Carrier:
  _____
- ❑ **Covered by an individual Health plan.**
  Insurance Carrier:
  _____
- ❑ **Covered by Medicare**
  Medicare Eligibility Date:
  _____
- ❑ **Other:**
  _____

I acknowledge that the available coverages have been explained to me by my employer, and I know that I have every right to apply for coverage. I have been given the chance to apply for this coverage and I have decided not to enroll myself and/or my dependent(s), if any, and understand that evidence of insurability may be required should I choose to apply for coverage at a later date. I have made this decision voluntarily and understand that I will not be eligible to enroll until next open enrollment or experience a qualifying event.

Effective January 1, 2014, I understand that the Healthcare Reform law requires all individuals to have qualified medical plan coverage or pay a penalty for each month for failing to have coverage. Your employer offers a medical plan that meets the minimum essential coverage and affordability rules, therefore this plan is a qualified plan which makes any eligible employee ineligible for a government subsidy through Covered California and it is my responsibility to report any changes to Covered California within 30 days. By declining my employer's coverage, I will be assuming responsibility in obtaining qualified medical coverage or be subject to IRS penalties for not complying with the law.

If I acquire a new dependent as the result of marriage, birth, adoption or placement for adoption, I acknowledge that I, and any dependents I may have, may request enrollment in my employer's group benefit plan(s) by applying for that coverage within 31 days of the marriage, birth, adoption or placement for adoption.

If I have indicated above that the reason for declining coverage for myself or my dependent(s) is coverage under another employer group benefit plan(s), I acknowledge that, if I or my dependent(s) involuntarily lose coverage under the other employer group benefit plan(s), I must request enrollment for myself and/or my dependent(s) in my employer group benefit plan(s) within 31 days. Otherwise, I understand I may not enroll myself and/or my dependent in my employer's group benefit plan(s) until the earlier or the end of my employer's next open enrollment period or 12 months and that "late entrant" provisions may apply.

X_____ _____ _____

Employee Signature **Employee Name - PRINT** **Date**

_____ _____

Date of Hire **Effective Date**