



EMPLOYEE BENEFITS - DECLINATION OF COVERAGE
SIG Waiver Form

Last Name: _____ First Name: _____ SSN: _____ DOB: _____
Address: _____ City: _____ State: _____ Zip: _____
District: _____ Bargaining Group: _____ Date of Hire: _____
Eff Date: _____ / Full Time Part Time / Monthly Payroll Frequency: 10 11 12

Please read and complete this form if any coverage is declined or refused by an eligible employee and their eligible family members:

Employee Benefits Eligibility with Schools Insurance Group:

All regular full-time employees working 20 or more hours per week. Check with your school district for effective date.

Eligible Dependents include:

- Your legal spouse
- Your qualified domestic partner
- Your children until age 26
- Your qualified domestic partner's children until age 26
- Your dependent child who is incapable of self-support because of a mental or physical disability

Your benefit elections or declination of coverage remains in effective until Schools Insurance Group's next Open Enrollment unless you have a qualifying life event as defined by the IRS:

- 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
- A change in your or your spouse's employment status from full-time to part-time or vice versa
- A substantial change in your benefits coverage or a spouse's coverage
- The addition or separation of a qualified domestic partner
- Change in eligibility for Medicaid or Children's Health Insurance Program (CHIP) subsidy

If you experience a family status change and want to change your benefits, you MUST contact Human Resources within 30 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 30 days after your other coverage ends.

(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 life 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 30 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 30 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