ESCONDIDO
City of Choice

Health Insurance Waiver of Coverage Form
Plan Year 2020

Employee Name (please print): _____ Employee ID Number: _____

Complete the following information for dependents for whom you are waiving coverage, including yourself, if applicable. **Proof of other coverage is required for all new hires.**

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I understand the City is making a qualifying offer of coverage in accordance with the Employer Mandate of the ACA. I voluntarily waive this coverage and understand that my waiver may affect eligibility for subsidized insurance coverage on state or federally facilitated health exchange. I hereby certify that I have been given the opportunity to elect group insurance benefits that are available to me through the City's Benefit Plan. I understand that by signing this form, I am waiving coverage for myself and/or my eligible dependents and that I will not be eligible to enroll in the benefit program until the next open enrollment period, unless I experience a family status change or qualifying event.

If applying for the opt-out incentive, I certify that my dependents and I (for whom I am waiving coverage) are enrolled in other group health coverage that is deemed to be minimum essential coverage. I understand that if I choose to opt out from coverage, that the opt-out incentive will be taxable. Additionally, I understand that I can use this compensation for any purpose, but these monies are not intended to reimburse me for an individual plan in the marketplace or a state exchange plan.

I further understand that I will not be able to revoke this waiver and elect coverage until the next open enrollment period for coverage effective the first of the following year, unless I:

- Lose coverage either under another group health plan or insurance coverage. I understand this does not apply if I lose coverage because I fail to pay premiums on a timely basis or if my coverage is terminated for cause.
- Experience a qualifying change in status.

To take advantage of a special enrollment, I must request to enroll within 31 days of the specified event.

If I receive an opt-out incentive for waiving a level of medical insurance, I understand that participation in the program requires current eligibility. If my dependents become ineligible under the City's health plan (e.g. through divorce or dependent maximum age limit) during the time I am being paid this incentive, I will notify the Human Resources Benefits Division immediately. If eligibility for incentive ends, I would forego any further incentives and understand overpayments must be repaid in full to the City. I authorize automatic repayment to the City through payroll deduction for any opt-out incentives received for any period later determined ineligible. **I understand that I must submit a Waiver of Coverage form for each plan year.** If I fail to do so during the annual open enrollment period, I will be automatically ineligible for opt-out incentives the following calendar year.

_____ _____

Employee's Signature Date

OPT-OUT INCENTIVE ELIGIBILITY RESTRICTIONS

A domestic partner eligible under this program must be a registered domestic partner through the State of California or other recognized Municipal or State governmental law.

If you and your spouse (or registered domestic partner) are both employed by the City of Escondido, the City rule allows for only one party to request and receive the monthly incentive for waiving their health insurance coverage. The employee who is waiving the level of coverage will receive the incentive.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in one of the City's plans if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependent's other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing towards the other coverage). If mid-year enrollment is requested due to loss of other coverage, you will be required to provide proof of loss of coverage through the other health plan in order to enroll on the City's plan.

In addition, you may be able to enroll yourself and your dependents on your benefit plans mid-year under a family status change that would include:

- Your marriage
- Birth, adoption or placement for adoption of an eligible child
- State registration of a domestic partner
- A change in your child's eligibility for benefits
- Change in address that affects eligibility for coverage
- A significant change in your or your spouse's health coverage or cost of benefit
- Receiving a Qualified Medical Child Support Order (QMCSO)

However, you must request enrollment within 31 days after the event triggering the newly eligible dependent. To request special enrollment, contact the City's Human Resources Benefits Division at (760) 839-4856. The City will request documentation for proof of newly eligible dependents.

Failing to accurately complete and return this form for each person for whom you are declining coverage will eliminate this special enrollment opportunity for that person(s), even if other coverage is currently in effect and is later lost. In addition, unless you indicate that you are declining coverage because other coverage is in effect, you will not have this special enrollment opportunity for the person(s) covered by this statement.

Special enrollment rights also exist in the following two circumstances, in which you or your dependents will have sixty (60) days from the date of the eligibility event to request special enrollment in the group health plan coverage:

- If you or your dependents experience a loss of eligibility for Medicaid or your State Children's Health Insurance Program (SCHIP) coverage; or
- If you or your dependents become eligible for premium assistance under an optional state Medicaid or SCHIP program that would pay the employee's portion of the health insurance premium.

LOSS OF DEPENDENT ELIGIBILITY

Generally, you may only change your benefit plan choices during the annual benefits open enrollment period. However, any change that results in a dependent becoming ineligible **must be taken care of immediately**.

If you have a family status change that results in the loss of eligibility for a covered dependent, you must notify the Human Resources Benefits Division within 31 days of the change. Family status changes resulting in the loss of dependent eligibility include:

- Your divorce, legal separation, or annulment
- Your legal dissolution of a State registered domestic partnership
- Death of your spouse, domestic partner, or covered child
- A change in a child's eligibility for benefits (i.e. overage or no longer your dependent)

Notifying the Human Resources Benefits Division of a loss of dependent eligibility, within 31 days of the change, protects an eligible dependent's COBRA continuation of medical insurance privilege. It also prevents your liability for any incentives, premiums or claims paid by the City for an ineligible dependent. If you are unsure whether you have a family status change that affects your benefits, or if you want further clarification of the family status change laws, contact the Human Resources Benefits Division at (760) 839-4856.