San Diego Community College District

Health Care Coverage Waiver Form
2019 Plan Year

Employee Name: _____
(Last (First) (MI)

Employee Number: _____
(Employee ID or Social Security Number)

On behalf of myself and my eligible dependents (if any), I waive the option to enroll in the San Diego Community College District health insurance that is offered to me for the 2019 plan year for following reason:

- ☐ I am covered under another group plan as a spouse/domestic partner or dependent
- ☐ I am covered by Medicare or Veterans Program
- ☐ I have purchased subsidized coverage through state or federal Exchange
- ☐ Other coverage – name of carrier: Click here to enter text.
  This other coverage is: ☐Individual ☐COBRA ☐TriCare ☐Medicaid ☐Employer Group Plan

I understand that I am waiving:

- ☐ Medical Coverage Only
- ☐ Dental and Vision Coverage Only
- ☐ Medical, Dental, and Vision Coverage

For the employee declining to enroll in the San Diego Community College District health care coverage listed above, please provide the following information:

Subscriber Name: _____

Carrier Name: _____ Group/Policy Number: _____

Notice of Enrollment Rights

By signing below, I certify that I have been given an opportunity to apply for coverage for myself and my eligible dependents (if any). I am declining enrollment as indicated above. I understand that I am declining enrollment for myself or my eligible dependents because of other health insurance or group health plan coverage. I may be able to enroll myself and my eligible dependents in this plan if I lose, or my eligible dependents lose eligibility for that other coverage.

I understand that I must request enrollment no more than 30 days after the date the other health plan coverage ends. If I do not do so, I will not be able to enroll until my employer's next annual open enrollment period.

In addition, I understand that if I have a newly eligible dependent as a result of marriage, birth, adoption, I may be able to enroll myself and my eligible dependent(s). However, I must request enrollment within 30 days after the marriage, birth, or adoption.

I understand that in order to request special enrollment or obtain more information, I should contact the benefits office at 619.388.6587.

Employee Signature: _____ Date: _____

Human Resources Signature: _____ Date: _____