

LOS RIOS COMMUNITY COLLEGE DISTRICT

MEDICAL PLAN WAIVER STATEMENT

LAST NAME	FIRST NAME	MI	EMPLOYEE ID
<u>GROUP SPONSOR:</u>			
LOS RIOS COMMUNITY COLLEGE DISTRICT			

I have been given the opportunity to enroll in a group medical plan sponsored by Los Rios Community College District. After consideration, I have decided to waive coverage for:

My self and all dependents     My Spouse/Domestic Partner     My Children/My other dependents

Reason for Waiver (please check at least 1 box and complete):

I am declining coverage for myself because I am covered under a medical plan not affiliated with Los Rios. This coverage is provided through:

- Military                       COBRA                       HMO     Medicare/Medicaid
- Individual Policy             My Spouse's/Domestic Partner's employer \_\_\_\_\_
- Other Insurance (Carrier's Name) \_\_\_\_\_

I am declining coverage for my Spouse/Domestic Partner because he/she is covered under another medical plan. Insurance Carrier's Name \_\_\_\_\_

I am declining coverage for my child(ren)/my other dependents because they are covered under another medical plan. List names \_\_\_\_\_ Insurance Carrier's Name \_\_\_\_\_

I am declining coverage for my Spouse/Domestic Partner and /or children and/or my other dependents. They are not covered under another medical plan. List names \_\_\_\_\_

I understand that if I later decide to apply for coverage for myself or any dependents for whom I am waiving coverage at this time, the insurance company may exclude me, or any dependent for whom I am waiving coverage at this time, from coverage for a period of 12 months from the date of my subsequent application and may impose a six-month pre-existing condition exclusion that would take effect at the end of the 12 month period. I also understand that at the time of my subsequent application for coverage, I will have to comply with the applicable group medical plan agreement for Policy Certificate requirements for eligibility and enrollment. **NOTE: (Pre-existing condition exclusions do not apply to a Health Maintenance Organization (HMO); it applies to a Preferred Provider Option (PPO)).**

This waiver will not apply if:

- A. \* you or your waiving dependents were covered under another employer's medical plan at the time of waiver;
- \* you execute this form at the time of waiver;
- \* you have lost coverage as a result of termination of employment, termination of the other plan's coverage, cessation of an employer's contribution, or divorce; and
- \* you request enrollment within 30 days of loss of other coverage or employer contribution.
- B. the individual elects a different medical plan during an open enrollment period; or
- C. a court orders the coverage of a spouse or minor child, and a request for enrollment is made within 30 days of the issuance of the order.

\_\_\_\_\_  
Employee Signature                      Date

\_\_\_\_\_  
Spouse Signature                      Date

Distribution: White: Employee Benefits

Canary: Employee

BS #96 04/2009