OPT-OUT OF MEDICAL BENEFIT FORM

1. PRIOR TO DECLINING COVERAGE, PLEASE READ THE FOLLOWING STATEMENT:

I hereby voluntarily and knowingly waive/cancel my medical benefits offered by San Bernardino Community College District which are or may become available to me or to my dependents under the plan. I understand I am declining the following health benefits for myself and any eligible dependents:

You must initial below:

_______ Medical

I understand that as a result of this waiver, I will not be able to obtain medical insurance coverage for myself or for my dependents through the District except during the annual enrollment period each year. The only exception to my inability to obtain coverage through District benefit plan(s) will be if I should lose other medical coverage due to a qualifying life event, similar to which I have declined, that was being provided through a source other than the District *and* I complete enrollment forms within 30 days of the event.

I understand that this agreement will remain in effect until June 30, 2010, and I will be required to submit a new waiver form, along with proof of other coverage, for the upcoming plan year effective July 1, 2010.

I certify by my signature below that I understand by requesting to waive only my medical benefits. The District will still continue any other plan that I am currently enrolled in including dental, vision, and chiropractic through June 30, 2010 and any other alternative insurance benefits to me including **Basic Life Insurance** and the **Employee Assistance Program**. I will receive no additional compensation or additional consideration whatsoever for waiving my right and entitlement to these benefits beyond the $250 per month stipend. I understand that this monthly stipend may be considered a compensable benefit and subject to the appropriate taxes and applicable retirement contributions. I also further fully release the District from any and all claims of liability which are related in any way to my sole decision to decline coverage.

2. REASON FOR DECLINING COVERAGE:

☐ I elect to decline coverage for myself and any eligible dependents through the District health plan because

- ☐ I/We have coverage under another employer's health benefit plan.
- ☐ I/We have coverage as a dependent through another employer's health benefit plan.
- ☐ I/We have other coverage. Please give details:

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3. PROOF OF OTHER COVERAGE:

I understand that I must show proof of coverage of medical coverage for myself and any eligible dependents in order to waive District Health Benefits.

☐ Certification of health insurance from a secondary source for myself and any applicable dependents is attached (i.e. photocopy of current benefits card, documentation from insurance provider or spouse's employer).

4. AUTHORIZATION:

I have had the opportunity to carefully review this document, and to investigate my options with respect to the District medical benefits, and it is my personal decision that this waiver is in my own best interest, and I sign it freely without threat of coercion or promise of additional benefit beyond a **monthly stipend of $250.00**.

Signature of Employee	Printed Name	Date
Signature of Spouse/Domestic Partner	**Printed Name**	**Date**