TEMPORARY UNIT MEMBERS WORKING IN THE NON-CREDIT FTES GENERATING PROGRAM WHO ARE ELIGIBLE FOR DISTRICT CONTRIBUTION TO KAISER MEDICAL BENEFITS

APPLICATION FOR WAIVER OF DISTRICT CONTRIBUTION TO KAISER MEDICAL BENEFITS

TO: Benefits Office

FROM: _____ _____
Employee Employee ID #

I wish to apply to the District for a waiver of the District's contribution to my Kaiser medical benefits and that of my dependents. In applying for this waiver, I hereby certify and document with attached proof of enrollment that my tax dependents and I have other non-individual health plan coverage (e.g. other employer plan, Tricare, Medicare, Medi-Cal).

I understand that in applying for the waiver of Kaiser medical benefits, I may only reinstate Kaiser medical benefits during the District's open enrollment or based on a Mid-Year Qualifying Event as defined by SISC (Self-Insured Schools of California), our Benefits Administrator. I understand that in applying for this medical benefit waiver by October 1, I must accept the consequences of my decision which may include, but are not limited to:

a. Changes in the law or insurance carrier procedures, which would preclude this option;
b. Future changes in the District-offered medical benefits.

In the event of loss of coverage under another plan, I understand that I may reinstate Kaiser medical benefits, if eligible, but that I must apply within 31 days of the date of loss of coverage.

I understand that I will not receive any monetary remuneration from the District in lieu of this coverage.

_____ _____
Date Employee Signature

_____ _____
Date Benefits Office