SANTA ROSA JUNIOR COLLEGE

WAIVER OF HEALTH COVERAGE
For Classified employees who work less than 50%

Effective Date:_____

I decline dental coverage for:

☐ Myself Only ☐ Myself & Spouse ☐ Myself, Spouse & Child(ren)
☐ Spouse Only ☐ Child(ren) Only ☐ Spouse & Child(ren)

I decline vision coverage for:

☐ Myself Only ☐ Myself & Spouse ☐ Myself, Spouse & Child(ren)
☐ Spouse Only ☐ Child(ren) Only ☐ Spouse & Child(ren)

Reason for Declining Coverage:

- I/We/They are covered under another employer sponsored dental or vision plan. Other coverage information:
  Employer: _____
  Carrier: _____

- I am declining dental/vision care insurance coverage for my dependents due to the following reasons:

_____
_____

If you are declining coverage for yourself or your dependent(s) because they have coverage elsewhere and they subsequently lose coverage, you may enroll your dependents immediately provided you notify the district within 30 days of loss of coverage. You must submit a completed and signed change form along with a copy of the Certificate of Coverage from the "coverage elsewhere" or evidence of loss of coverage elsewhere.

In addition, if you have a new dependent as a result of marriage, birth, adoption, placement for adoption, or placed in your home as a result of court ordered custody or guardianship, you may enroll your dependents, provided you request enrollment within 30 days following the date of this event. Again, you must submit a completed and signed enrollment or change form.

If you fail to notify your employer that your dependent(s) is (are) no longer eligible for coverage under your plan, they may not be eligible for continuation coverage under the COBRA or CalCOBRA law.

I have read and understand the above notification. I understand that, if I decline coverage for my dependents, I will not be able to enroll them in coverage until the district's Open Enrollment period for an October 1 effective date or because of one or more the events listed above.

Print Name: _____ SSN: _____

Signature: _____ Date: _____