SANTA ROSA JUNIOR COLLEGE

# WAIVER OF HEALTH COVERAGE

**Effective Date of Health Insurance Offer: _____**

**EMPLOYEE INFORMATION**

Last Name: _____

First Name: _____

Employee ID#: _____

I acknowledge that I have been offered the opportunity to participate in the Santa Rosa Junior College group health insurance program.

I decline enrollment at this time because:

☐ I do not wish to participate in the company's group health insurance program.

☐ I have other medical coverage provided by:

☐ Insurance company name: _____ Policy # _____

Through (other employer name / spouse's employer): _____

☐ I currently have coverage through the Market Exchange.

I understand that Santa Rosa Junior College has provided me with the opportunity to participate in the company's group health insurance program and I am electing to waive health insurance coverage for myself and my eligible dependents (if applicable) at this time. I acknowledge that the employer's coverage meets Minimum Essential Coverage (MEC), Minimum Value and Affordability requirements.

By signing this form, I am aware that I am making a binding election for my health insurance coverage for the current plan year. I understand that I may not change my health care elections during the current plan year unless the change is a result due to a "qualifying event" allowable under the IRS Code and insurance carrier contracts. A "qualifying event" must be reported within 30 days of the event and provide supporting documentation must be provided. If I fail to report a "qualifying event" within 30 days, I understand that I will not be able to make an election until the next Annual Open Enrollment Period.

Employee Signature: _____ Today's Date: _____