

INSURANCE WAIVER

Only Complete If You Are Waiving Medical Coverage

Employee Name: _____

The Yolo County Office of Education (YCOE) Employee Benefits Plan offers medical coverage as required under the Affordable Care Act (ACA). If you are waiving medical coverage, please complete the waiver information below.

Medical Coverage:

I hereby state that I am waiving participation in the employer sponsored medical plan at YCOE because:

- I am covered under spouse's group insurance policy.
- I am covered under an individual policy.
- I choose to decline medical coverage.

This alternate coverage is:

Carrier: _____

If you choose to waive benefits or make no changes at this time, your next opportunity to enroll in the plan(s) will be during the annual open enrollment period next year. The only exception to this is if you have a HIPAA qualifying event and enroll within 30 days of the date the event occurs. Examples of HIPAA qualifying events would be loss of prior coverage, marriage, or birth/adoption of a child.

Employee's Signature

Date

**Healthcare Reform requires you and each member of your family to either have health coverage
or pay a tax penalty with your federal tax return.**