Santa Barbara Unified
Every child, every chance, every day.

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Waiver of Medical/Dental/Vision Coverage
For All Part-time and Full-time Employees

I, _____(printed name of employee) Employee ID #:_____

Declare as follows:

1) I am a part-time or full-time employee of the Santa Barbara Unified School District.

2) I understand that I am entitled to have the District pay its normal contribution provided I pay the balance of such required premium, if any.

3) I realize that should I waive coverage now and later decide to enroll in the District Health plan, **I WILL NOT HAVE THE OPPORTUNITY TO DO SO UNTIL THE NEXT ANNUAL OPEN ENROLLMENT PERIOD OR UNLESS I MOVE FROM PART-TIME TO FULL-TIME POSITION OR HAVE QUALIFYING EVENT. If I decline coverage during a leave of absence, I understand that I am eligible for continued health insurance through COBRA while on a leave and I acknowledge that I have been notified of these rights and am waiving my rights to such coverage.**

4) Effective _____* I do not (or no longer) wish to be covered under the Districts' Health Insurance Plans; and I hereby request and instruct the District not to make, and I hereby relinquish and waive my right to have the District make, any (further) insurance premium payments on my behalf. In addition, I advise the District that I will not make any (further) payments of my share of such insurance premiums.

5) I hereby agree to indemnify and hold harmless the District, its officers and employees, from and against any claim, liability, cost and expense of whatever nature which may arise from or as a result of the non-payment by the District of the insurance premium pursuant to the foregoing instructions.

6) I understand that if I choose to waive coverage considered affordable and minimum essential under the Patient Protection and Affordable Care Act (ACA), I will not qualify for government credits and subsidies to purchase individual health insurance on the Marketplace. I acknowledge that the Employer has offered me affordable minimum essential coverage, as defined under the ACA. I have read the above, and I understand the consequences of my waiver of coverage. At this time, after careful review, I elect NOT to enroll in the major medical coverage offered by the Santa Barbara Unified School District.

_____ _____ _____
Signature Department Name/School Site Date

***THIS DATE MUST BE THE FIRST DAY OF A MONTH (10/1/18 during Open Enrollment)**