Temple City Unified School District

Waiver of Coverage under the School District's Group Healthcare Plan

All benefits eligible employees who choose to waive medical coverage under the district's group plan must: Complete page 1 of the waiver form. CSEA 823 members must also complete page 2.

Employee Name: _____ **Employee SS#** _____

Employee Eligibility Start Date* _____ **Plan Year** January 1, 2020 – December 31, 2020

**This is the date that the coverage would have started had you enrolled in the coverage*

On behalf of myself, my spouse (if any) and my dependents (if any), I waive the option to enroll in the School District's Group Healthcare Plan (the "Plan") offered for the following reasons:
Please select from the following all that apply:

- ☐ I have healthcare coverage through a group or individual healthcare plan outside of the school district.
  Carrier: _____ Policy number: _____
- ☐ I am covered by Medicaid.
- ☐ I am covered by Medicare.
- ☐ I have other healthcare coverage for myself: _____(*Explain.*)
- ☐ I have other healthcare coverage for my dependents: _____(*Explain.*)
- ☐ I am exempt: _____(*Explain.*)
- ☐ My dependents are exempt: _____(*Explain.*)
- ☐ I do not wish to enroll myself, my spouse (if any) or dependents (if any) in healthcare benefits at this time.

I acknowledge that the Plan was explained to me, including notice that the Plan satisfies the Affordable Care Act's definitions of minimum value and affordability. As a result, I, my spouse (if any), and my dependents (if any) (collectively, the "Coverage") will not be eligible for premium tax credits or cost sharing assistance through the Healthcare Exchange.
I understand that if I, my spouse (if any) and/or my dependents (if any), do not have healthcare coverage I may be assessed a tax penalty by the Internal Revenue Service.
I understand that if I wish to enroll myself, my spouse (if any), and/or my dependents onto the Plan at a time other than during my School District's Open Enrollment, in addition to the School District's requirements for eligibility, the requirements for Special Enrollment, as summarized below, must also be satisfied. Otherwise, I will need to wait until the next Open Enrollment.
I understand that I have the right to apply for Coverage under the Plan and have been provided the opportunity to apply for such Coverage. However, I have declined to enroll myself, my spouse (if any), and my dependents (if any). I have made this decision voluntarily.
I have reviewed this form, understand its contents, and have provided my answers herein in order to waive coverage under the School District's Healthcare Plan, and I certify that all of the information completed on this form is true, correct and complete.

_____ _____
Employee Signature **Date**

Special Enrollment

If you are declining enrollment onto the school district's healthcare plan during the school district's Open Enrollment for yourself, your spouse or your dependents because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents onto the school district's healthcare plan outside of Open Enrollment if you, your spouse or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your, your spouse's or your dependents' other coverage). However, you must request enrollment within ***30 days*** after your, your spouse's or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself, your spouse and your dependents onto the district's healthcare plan outside of Open Enrollment. However, you must request enrollment within ***30 days*** after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact Lucy Lin, who can be reached at 626-548-5123.

Temple City Unified School District

Conditional Opt-Out Payment Arrangement Attestation under the Temple City Unified School District's Group Healthcare Plan

Employee Name: _____ **Employee SS#** _____

Employee Eligibility Start Date* _____ **Plan Year** January 1, 2020 – December 31, 2020

**This is the date that the coverage would have started had you enrolled in the coverage*

The Conditional Opt-Out Payment option is only available to CSEA 823 Employees that are eligible to receive Health benefits.

I provide this Attestation in order to receive Opt-Out Payment(s) from the School District through an Opt-Out Payment Arrangement, which applies for the Plan Year starting from my Eligibility Start Date ("Coverage Period"), and specifically attest to each of the following statements:

- I have declined coverage for myself to enroll onto the Plan.
- My tax family** have or will have an alternative group medical plan that meets minimum essential coverage (other than coverage in the individual market, whether or not obtained through the Marketplace) ("Alternate Coverage") during the Coverage Period.

  ***The term "tax family" consists of the taxpayer, spouse (if any and filing jointly), and all other individuals for whom the taxpayer expects to claim a personal exemption for the applicable tax year or years that begin or end in or with the Plan Year.*
- I agree to provide proof that I, and my spouse (if applicable) and any dependents (if applicable) is (are) enrolled in Alternate Coverage. I further agree to provide such proof no earlier than a reasonable period before the Coverage Period but that no less frequently than every Plan Year to which I seek Opt-Out Payment(s). I further understand that providing such proof at the School District's regular annual open enrollment period will satisfy the foregoing requirement.
- I further understand that I will not be eligible for Opt-Out Payment(s) in the event that the School District knows or has reason to know that I or any member of my expected tax family does not have the required Alternative Coverage.

I have reviewed this form, understand its contents, and I certify that all of the information completed on this form is true, correct and complete.

_____ _____

CSEA 823 Employee Signature **Date**

PERSONNEL OFFICE ONLY
Eff. Date_____
To Payroll_____
Waiver Form Rec'd._____
Dep. Docs. Rec'd._____
Input Date_____
Processed By