Waiver of Employee Medical Benefit Coverage

Name: _____ **SSN:** _____

Employer: Tehama County Department of Education

Effective Date: _____ **Full-Time:** ___ **Part-Time:** ___

I hereby certify that the benefits provided under the Group Medical Insurance as provided for by my employer have been explained to me. I have been given an opportunity to participate in all of the plans offered and that I voluntarily decline to do so. I understand that by refusing to participate in the plans personally, I surrender any rights I may have had to cover myself and my dependents. Should I wish to become covered at a later time, I understand that I must wait until the next open enrollment period, offered by Tri-County Schools Insurance Group, to elect coverage unless otherwise eligible to do so by law.

I understand that my employer does not offer compensation, in any form, in lieu of benefits.

_____ _____

Signature of Employee | Signature of Personnel Office

Date: _____ Date: _____

I verify that I have other health coverage as follows:

_____ _____

Insurance Company | Group #

1445 BUTTE HOUSE ROAD, SUITE A ● YUBA CITY, CA 95993 ● (530) 822-5299 FAX (530) 822-5284

Distribution: White: Tri-County Schools Insurance Group Yellow: Tehama County Department of Education Pink: Employee