Human Resources / Employee Benefits
15600 Concord Circle, Morgan Hill, CA 95037
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Benefit Decline / Medical Waiver Form

Morgan Hill Unified School District (The District) believes that it is essential for all employees to be enrolled in vision, dental, and medical plans. Our group medical plan is a key component to an employee's compensation package. The majority of Ameicans have group medical coverage through their employer or their spouse's employer. The Health Insurance Marketplace (eg. Covered California) is also available due to the regulations of the Affordable Care Act.

Currently, our medical plan allows employees to waive medical coverage. However, waivers may contribute to an increase in the District's future rates for medical plans and an overall decline in the District's ability to secure offers and quotes from other insurance carriers. Rates may also be affected by changes to the risk pool, such as high utilization.

Employees may waive medical coverage if the following requirements are met:

- Proof of other coverage is provided annually during Open Enrollment
- Proof of other coverage is attached to this form (eg. ID card, invoice, confirmation letter, etc.)
- Proof includes the name of the employee and coverage period

Employee Information		
First Name:	Middle Name:	Last Name:
Classification:	Job Title:	

Employee affidavit:
My signature below certifies that I have been given the opportunity to participate in all of the health benefits offered by the District, yet I am declining to enroll in the District's medical plan.

I am waiving medical coverage for myself in the District's medical plan because I have other medical coverage. By signing the form, I understand the requirements for opting out as described above and have had all my questions answered by the District. It is my sole responsibility to report my medical coverage accurately when I file my income tax returns and report information regarding the Affordable Care Act.

I acknowledge that future medical coverage will only be added during Open Enrollment or if I have experienced a qualifying event. If a qualifying event occurs, I will submit the necessary forms and proof to the District within 30 days of the occurrence if I want to enroll in medical benefits that I previously declined or if I need to change any benefits.

I understand that the District highly recommends that all employees be enrolled in vision, dental, and medical plans and that all employees have a disability policy, especially since California State Disability Insurance (SDI) is not available to all employees. It is my responsibility to monitor my vacation and sick leave balances. I will read my union contract for a thorough understanding of allowed leaves of absences and how my pay and benefits might be affected.

_______________________________________ ____________________
Employee's Printed Name and Signature Date