PRINT NAME_____ **Emp. ID**_____

MEDICAL INSURANCE WAIVER Part-Time Employees (30-39 Hours per Week)

I hereby acknowledge I have been given an effective opportunity to enroll in health coverage offered by Del Mar Union School District for the plan year from January 1, 2018 to December 31, 2018 and the coverage offered meets the standards of affordable, minimum value coverage as defined by the Affordable Care Act.

I waive district medical coverage for myself and attest that I will have other minimum essential medical coverage for the period year from January 1, 2018 to December 31, 2018 through the medical insurance carrier:

_____

This coverage is (check box that applies to your other medical coverage):

- ☐ Other employer sponsored group coverage (e.g., through a spouse or domestic partner)
- ☐ TRICARE
- ☐ Medicare
- ☐ Medi-Cal
- ☐ COBRA

Furthermore, I understand:

- Other minimum essential health coverage cannot include coverage purchased on the individual market, including through Covered California.
- That the district, at its sole option, may in the future require me to enroll in the District medical plan.
- That I will not be able to enroll in any district medical insurance plan until the next open-enrollment period, unless one of the following qualifying events occurs, **AND I NOTIFY THE DISTRICT INSURANCE OFFICE WITHIN 30 DAYS OF THE EVENT WITH WRITTEN PROOF:**

    1. Loss of coverage due to termination of employment of spouse/registered domestic partner
    2. Change in spouse's/registered domestic partner's employment status (full to part time)
    3. Family status change (marriage, birth, adoption, divorce, legal separation or Qualified Medical Child support order)

- That I must renew this waiver annually during open enrollment.

I have read, I understand, and I agree to all the information above.

SIGNATURE_____ **DATE**_____