PRINT NAME_____ **Emp. ID**_____

MEDICAL, DENTAL AND VISION INSURANCE WAIVER
Full-Time Employees

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, 2022 to December 31, 2022 and the coverage offered meets the standards of affordable, minimum value coverage as defined by the Affordable Care Act.

I waive district coverage (which includes medical, dental and vision insurance) for myself and attest that I will have other minimum essential medical coverage for the period year from January 1, 2022 to December 31, 2022 through the medical insurance carrier:

_____

I will provide proof of coverage which is through (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 by declining medical coverage, I understand that I do not have the option to enroll in dental or vision coverage.
- That the district, at its sole option, may in the future require me to enroll in district medical, dental and vision insurance plans.
- That I will not be able to enroll in any district medical insurance plan (nor dental and vision) 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 enroll in the District life insurance plan.
- 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**_____