PRINT NAME_____ **Emp. ID**_____

MEDICAL, DENTAL AND VISION 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, 2024 to December 31, 2024 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, 2024 to December 31, 2024 through the medical insurance carrier:

Carrier name:_____

I will also provide proof of coverage (copy of current medical card) which is through (check box below 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:

- 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**_____