HEALTH INSURANCE OPT OUT FORM

Please complete this form if you carry medical insurance through a source other than Placer County and are waiving medical coverage under the County's benefit plans.

Employee Printed Name: _____

By signing this form you are confirming the following:

- I elect ***not to enroll*** in any of the medical plans that Placer County offers to its employees.
- I certify that I have medical coverage for myself and eligible dependents elsewhere that is comparable to one of the plans offered by Placer County.
- I understand that if I have other insurance coverage for myself and my tax dependents (spouses employer plan, Tricare, Medicare, Medi-Cal, etc.), that I may elect an employer contribution to one of the County's 401(k) deferred compensation plans.
- I understand that I will not be eligible to enroll in any of Placer County's medical plans until the next open enrollment period, or within 30 days of a qualifying life event.
- I understand that Placer County requires documentation verifying my medical insurance elsewhere (A copy of your insurance statement or card is sufficient).
- This certification will remain in effect as long as I continue to waive medical coverage.

Please send the completed form via inter-office mail or the US postal service to:

Placer County Human Resources Department

ATTN: Benefits

145 Fulweiler Ave, Suite 200

Auburn, CA 95630

_____

Employee Signature

_____

Date