## TEMPORARY UNIT MEMBERS WORKING IN THE NON-CREDIT FTES GENERATING PROGRAM WHO ARE ELIGIBLE FOR DISTRICT CONTRIBUTION TO KAISER MEDICAL BENEFITS

## APPLICATION FOR WAIVER OF DISTRICT CONTRIBUTION TO KAISER MEDICAL BENEFITS

TO:	Benefits Office	Benefits Office	
FROM:	Employee	Employee ID #	
of my depe	ndents. In applying for this	er of the District's contribution to my Kaiser medical benefits and that vaiver, I hereby certify and document with attached proof of I have other non-individual health plan coverage (e.g. other employer	
benefits du (Self-Insure	ring the District's open enro ed Schools of California), ou nefit waiver by October 1, I	iver of Kaiser medical benefits, I may only reinstate Kaiser medical lment or based on a Mid-Year Qualifying Event as defined by SISC r Benefits Administrator. I understand that in applying for this must accept the consequences of my decision which may include, but	
	nanges in the law or insurance ture changes in the District-	e carrier procedures, which would preclude this option; offered medical benefits.	
	<u> </u>	nother plan, I understand that I may reinstate Kaiser medical benefits, 31 days of the date of loss of coverage.	
I understan	d that I will not receive any	monetary remuneration from the District in lieu of this coverage.	
Date		Employee Signature	
Date		Benefits Office	