UPM/AFT
TEMPORARY CREDIT UNIT MEMBERS ELIGIBLE FOR KAISER MEDICAL BENEFITS

APPLICATION FOR WAIVER OF DISTRICT MEDICAL BENEFITS

TO: Benefits Office

FROM: _____ _____
Employee Employee ID #

I wish to apply to the District for a waiver of my Kaiser medical benefits and that of my dependents. In applying for this waiver, I hereby certify and document with attached proof of enrollment that my tax dependents and I have other non-individual health plan coverage (e.g. other employer plan, Tricare, Medicare, Medi-Cal).

I understand that in applying for the waiver of Kaiser medical benefits, I may only reinstate to Kaiser medical benefits during the District's open enrollment or based on a Mid-Year Qualifying Event as defined by SISC (Self-Insured Schools of California), our Benefits Administrator. I understand that in applying for this medical benefit waiver by October 1, I must accept the consequences of my decision which may include, but are not limited to:

a. Changes in the law or insurance carrier procedures, which would preclude this option;
b. Future changes in the District-offered medical benefits.

I understand that upon approval by the Benefits Office, I will receive up to $1500, or pro-rata share which reflects the plan year (October 1 to September 30). I understand that I shall receive half of the waiver payment ($750) by December 15th, with the balance being paid no later than March 15th of the following semester, if I remain eligible for the waiver in that spring semester. For late starting classes, the balance will be paid no later than April 15th if I remain eligible for the waiver in that spring semester. I further understand that I must reapply to the Benefits Office for this waiver by October 1 of each year, and provide the necessary proof of enrollment. To reinstate Kaiser medical benefits, I must apply during the District's open enrollment to the Benefits Office.

Loss of Coverage:
In the event of loss of coverage under another plan, I understand that I may reinstate to Kaiser medical benefits, but that I must apply within 31 days of the date of loss of coverage. I would then receive a pro-rata share of the $1500 annual payment which reflects that portion of the year for which I waived medical benefits (October 1 to September 30).

_____ _____
Date Employee Signature

_____ _____
Date Benefits Office