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COLLEGE OF MARIN

UPM/MARIN CCD FORM F4.B

# Temporary Noncredit Unit Members' Application For Waiver of District Medical Benefits



To: Benefits Office

From: ______________________________
Print name

I wish to apply to the District for a waiver of the District's medical benefit coverage and that of my dependents and its contribution to the medical benefit coverage. In applying for this waiver, **I hereby certify and document with attached proof of coverage that I have comparable coverage under another plan.**

I understand that in applying for this waiver of the District's medical benefit and its contribution to my medical benefit, I must accept the consequences of my decision, which may include, but are not limited to:

a) My subsequent loss of the other medical coverage for any reason;
b) The time which will elapse before I may obtain District coverage;
c) Changes in the law or insurance carrier procedures, including but not limited to those which would preclude this option;
d) Future changes in the District-offered medical benefits and eligibility requirements.

Pursuant to Article 4, I understand that if the Benefits Office approves my application for a waiver, I will not receive any monetary remuneration from the District in lieu of the District contribution to medical benefits. To obtain the District contribution for medical benefits, I must apply when permitted to do so by the insurance carrier (e.g., upon a mid-year qualifying event or during open enrollment) if I am eligible for benefits at that time.

Employee Signature ______________________________ Date: ______________

**For Benefits Office Use Only:**

Benefits Office Signature ______________________________