County of Santa Cruz

Health Insurance Waiver

Annual Certification Required

I acknowledge I have been offered the opportunity to enroll in the CalPERS group health plan offering minimum essential coverage through the County of Santa Cruz for the __________ **plan year.**
In lieu of this coverage, I elect to waive/continue to waive the County's group health plan options because I have qualifying group health coverage that offers minimum essential coverage, as defined by the Internal Revenue Service (IRS). I understand that if I waive coverage for myself, I may not cover my dependents under the County's group health plan. I understand that if I waive the County's group health plan coverage, I may be eligible to receive cash in lieu of health coverage. This cash benefit is payable on a quarterly basis and is taxable income.

To receive the cash benefit for this conditional opt-out program, I must have: minimum essential coverage, as defined by the IRS through another group health plan (or other plan deemed acceptable by the IRS) for myself and for all dependents I reasonably expect to claim a personal exemption deduction for the taxable plan year to which the opt out payment applies; and I must provide the County with proof of and attestation to coverage on an annual basis during open enrollment.

I have attached the required proof of qualifying coverage in the form of a copy of a membership card or letter, AND a completed HBD-12 declining coverage.

If my alternate group health plan coverage terminates, I must notify the County of Santa Cruz Personnel Department Benefits Unit within 30 days and provide proof of my new alternate group health plan coverage or enroll in the County's group health plan, to avoid penalties associated with the Affordable Care Act (ACA). Failure to notify may result in owing the County significant costs for health premiums.

I certify, under penalty of perjury, that the proof of alternate group health plan coverage submitted, and the information provided on this form is true and accurate.

Employee Name: ______________________________ **Employee Payroll #:**______________

Employee Signature: ______________________________ **Date:** ____________________

Name of Alternate Group Health Plan: ______________________________

Provided Through:

☐ **A Santa Cruz County employee who is: my spouse/domestic partner/parent (Name of spouse/domestic partner/parent ______________________)**
☐ **Military**
☐ **Spouse/Domestic Partner/Parent**
☐ **Other** ______________________

All family members (spouse/dependent children) are covered by this alternate group health plan? Yes☐ No ☐

☐ **I am enrolled in Medicare, Medi-Cal, VA or Tri-Care (Does not qualify for the stipend benefit)**

Revised: 12/2023