County of Santa Cruz

Health Insurance Waiver
2025 Plan Year Form

ANNUAL ENROLLMENT 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 provide proof of and attest to having minimal essential coverage as defined by the Internal Revenue Service (IRS) through another group health plan (or other plan deemed acceptable by the IRS) for myself and for all individuals for whom the I reasonably expect to claim a personal exemption deduction for the taxable plan year to which the opt out payment applies. I must provide the County with proof of and attestation to coverage every plan year.

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 Form declining coverage.

If my alternate group health plan coverage terminates, I must notify the County of Santa Cruz Human Resources 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.

- **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 (which does not qualify for the stipend benefit.)**
  ☐ **Yes** ☐ **No**

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 (print):_____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 _____**