SCHOOLS INSURANCE GROUP

WAIVER FORM

Refusal of District Offered Benefit Plan Options

____________________	____________________	____________________
(District)	(Hire Date)	(Classification)

____________________	□ Full Time □ Part Time	____________________
(Employee Name)		(SS Number)

I hereby certify that the employee group benefit package provided by my employer has been explained to me. I have been given an opportunity to participate in all of the plans offered (Medical, Dental & Vision if district offered) and that I voluntarily decline to do so. By refusing to participate in all of the plans personally, I surrender all rights I may have had to cover my dependents and myself.

Special Enrollment Qualifying Event

Full time or part time employees who elect to sign a waiver not to participate in district negotiated plan options and have a loss of group coverage due to death, divorce or loss of coverage from a spouse's termination of employment may elect coverage during a special enrollment period. Enrollment must be requested within 30 days of the qualifying event and a Certificate of Creditable Coverage provided. Otherwise the option to elect coverage may be done only during the Plans approved open enrollment.

I understand that if I cannot provide a Certificate of Creditable Coverage as required under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) that my eligible dependents and I may be required to wait until the next open enrollment. I further agree to hold harmless my Employer, the Insurance Company and Schools Insurance Group of Placer and Nevada Counties for any claims incurred on my behalf or that of my eligible dependents.

I understand that the district must provide employee group benefits for all full time positions. Therefore, the district cannot offer cash in lieu of benefits.

I have read and understand the above notification. **I am declining all district offered benefits offered by my employer due to the following reason(s). If due to other coverage, list the name of the Plan(s):**________________________________

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Employee Signature____ Date____________________

District Personnel Signature____________________________________ Date____________________

Employer Section—Waiver Amount and Effective Date				
	WAIVE-CxxxSA $____________________			
	Mo	Day	Yr	

Waiver required for Full-Time Employees. Part-Time Employees' Waiver should be placed in District Personnel File.