Print Form

HUMAN RESOURCES
& DEVELOPMENT
TULARE COUNTY

VERIFICATION OF PROOF OF OTHER COVERAGE
PLAN YEAR 201n

- I have elected to waive the County's health insurance coverage for Plan Year 2014.
- I understand that I am required to provide written verification that will validate my coverage under another qualifying plan for Plan Year 2014. **Failure to provide such verification will result in the forfeiture of my Benefit Amount.**
- I understand that I am required to report ANY changes in my other coverage status within 30 days of the event date for Plan Year 2014 to HR&D - Benefits.

Please fill-in information below:

Employee Name:		**EE ID #:**
Insured / Subscriber Name:		
Relationship to Insured/Subscriber: ☐**SELF** ☐**SPOUSE** ☐**PARENTS** ☐**Other:** _____		
Employer/Group Name:		
Insurance Carrier Name:		
Effective Date:	**Group #:**	**ID#**
Plan Type: ☐**HMO** ☐**PPO** ☐**EPO** ☐**Other:** _____	**Coverage Level:**	
I am covered as:	☐**Primary**	☐**Dependant**

Acceptable forms eligible for Proof of other Coverage (Please select the type of documentation provided*):

☐ Health Insurance Identification card

☐ Statement from another employer: On company letterhead that includes verification of coverage levels and dates of coverage.

☐ Certificate of Creditable Coverage: Distributed by the carrier upon enrollment in the plan; also known as a HIPPA Certificate.

☐ COBRA General Notice: Must list names of the dependents that are covered.

☐ Medi-Cal – Current Notice of Action for Medi-Cal recipients

***Attach a copy of the proof listed above.**

By signing this form, I acknowledge that the above is true and accurate.

Signature: _____ Date: _____

The deadline to submit this information to HR&D Benefits is **November 30, 2013.**
Send via Fax to 559-730-2597; Scan and Email to OEHealth@co.tulare.ca.us; **or**
Mail to HR&D – Benefits Unit at 2900 W. Burrel Avenue, Visalia, CA 93291