HUMAN RESOURCES
& DEVELOPMENT
TULARE COUNTY

TULARE COUNTY 2019 HEALTH PLANS
DECLINATION OF COVERAGE

EMPLOYEE NAME: _____ **EMP ID:** _____

Reason for Waiving Coverage:

- ☐ Covered by another employer-provided group health plan.
- ☐ Enrolled in Medicare
- ☐ Enrolled in Champus or Champva (Military coverage)
- ☐ Receiving Medi-Cal
- ☐ Covered by an Individual Health Plan
- ☐ Other (explain) _____

I agree to the following *(initial each box after reviewing):*

☐ I understand that this election is irrevocable once submitted and I can only re-enroll myself and my dependents if I experience one of two specific situations: (1) I have lost other health insurance and must provide a Letter of Credible Coverage from the insurance company to Employee Benefits within 30 days of the termination date or (2) during the annual Open Enrollment period.

☐ I understand that I am opting out of the entire Health Insurance Plan, which includes: medical, dental, vision, prescription and mental health coverage.

☐ I understand that I must provide **written proof of other employer-sponsored group health insurance** as well as this completed form to Employee Benefits.

- Newly hired employees may elect to opt out during the first 30 days of employment.
- Existing employees may elect to opt out during Open Enrollment or a Qualifying Event.

☐ I verify that by electing not to participate in the County of Tulare's Health Insurance Plan, it does not constitute a violation of any court order or legal obligation that I may be subject to.

I have read and understand the above conditions and procedures for opting out of the health insurance plans offered by the County and acknowledge that I (and my dependents) have other, non-individual market, health insurance coverage through a qualified health plan.

Signature: _____ Date: _____