City of Santa Rosa

WAIVER OF HEALTH INSURANCE-POLICE

I, ____(name of employee) decline health insurance coverage for myself and all eligible dependents due to other health coverage. In lieu of selecting employer sponsored health coverage, employee is eligible to receive cash payment of $200 per month or have designated amount be placed in a dependent care reimbursement account by the City.

I choose to receive $200 cash per month in lieu of employer sponsored health coverage.

I choose to enroll in dependent care in lieu of employer sponsored health coverage.

	Monthly City Contribution	Monthly Employee Contribution	Per paycheck Amount	Yearly Total
Dependent Care	$____________	$____________	$____________	$____________
Total	$____________ ($416.65 max)	$____________	$____________ ($192.3 max)	$____________ ($4999.80 max)

THIS IS NOT AN ENROLLMENT FORM. EMPLOYEES WISHING TO ENROLL IN DEPENDENT CARE AND/OR MEDICAL REIMBURSEMENT ACCOUNTS MUST COMPLETE THE DEPENDENT CARE ENROLLMENT FORM.

Failure to elect health coverage during the initial enrollment period may result in no coverage for up to 12 months.

Persons signing the waiver will be allowed subsequent enrollment with the following conditions:

1. Persons who waive coverage because they are covered under another employer's health plan and then subsequently lose coverage due to certain "qualifying" events, such as a change in employment status of the employee. For this exception to apply, the person must enroll in the new plan within 30 days after termination of such coverage.

2. Persons who subsequently elect a plan during an open-enrollment period.

I attest to the fact I have read and understand the effect of this waiver.

____ Date ______________

Employee's signature