



Ensure the most current form is submitted. Refer to EMACS Forms/Procedures website.

DECLINATION AGREEMENT FOR ESSENTIAL HEALTH PLAN COVERAGE

The Patient Protection Affordable Care Act (PPACA) mandates that employers (the County) offer group sponsored medical plan coverage to employees, regularly working full-time as defined by PPACA. By completing this form, you are electing to decline the County's group sponsored Bronze medical plan.

DECLINATION

I acknowledge that I was offered participation in the County's group sponsored Bronze medical plan and I elect to decline enrollment, as a subscriber, in the group sponsored Bronze medical plan with San Bernardino County.

Employee ID	Rcd No.	Last Name, First Name	
Company		Department	Telephone

Declination Agreement

- I acknowledge that the San Bernardino County's group sponsored Bronze medical plan coverage information has been provided to me for consideration.
- I hereby release and hold harmless San Bernardino County, its officers, agents and employees from any liability arising from the fact that I am declining enrollment in a County's group sponsored Bronze medical plan and I hereby waive any rights to be afforded such coverage.

Employee Signature	Date
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This document/form incorporates use of e-signatures in accordance with the San Bernardino County Policy #03-12 and Standard Practice 1.

FORM MUST BE COMPLETED, SIGNED AND RETURNED TO EMACS-HR (MAIL CODE: 0030)

Office Use Only

Reviewed by:	EMACS-HR Staff (Print & Sign)	Date
Keyed by:	EMACS-HR Staff (Print & Sign)	Date

DISTRIBUTION: Original - EMACS-HR (0030)