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

OPT-OUT/WAIVER ELECTION AGREEMENT FOR MEDICAL AND/OR DENTAL COVERAGE

Must print in Black and Blue ink ONLY

☐ New Employee ☐ Open Enrollment ☐ Change in Status - Effective Date:

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

Refer to Opt-Out/Waiver for Medical and/or Dental Coverage procedure for further information

OPT-OUT

I elect to opt-out of my County-sponsored medical and/or dental coverage. I am *currently enrolled* in another employer's group medical and/or dental plan as specified below. **ALL FIELDS MUST BE COMPLETED**

	Name of Plan		**Employer Providing Coverage**
Medical:		Medical:	
Dental:		Dental:	

	Employer Contact to Verify Coverage		**Employer Contact Telephone**
Medical:		Medical:	
Dental:		Dental:	

	Attach proof of Coverage		**Effective Date of Coverage**
Medical:	Check appropriate box: ☐ Copy of Card ☐ Certificate of Coverage	Medical:	
Dental:	Check appropriate box: ☐ Copy of Card ☐ Certificate of Coverage	Dental:	

Note: Read the Opt-Out Agreement on page two of this form, sign and date

WAIVER TO ANOTHER COUNTY EMPLOYEE

I elect to waive my enrollment as a subscriber in the County-sponsored medical and/or dental plan(s). I will be covered as a dependent as specified below.

Provide the following information for the County employee you are waiving to:

Employee ID	Rcd No.	Last Name, First Name	Department

Relationship		**Name of Plan**	
☐ Spouse ☐ Domestic Partner ☐ Parent		Medical:	
		Dental:	

Note: Read the waiver agreement on page two of this form, sign and date

OTHER WAIVERS

Check applicable box:

☐ Medicare ☐ Elected Officials ☐ Other (specify) _____

DISTRIBUTION: *Original - EBSD-HR (0440)*
Copy - Department of Spouse/Domestic Partner or Parent (for Waiver only)

Opt-Out Agreement

I understand, accept and agree to the following terms and conditions:

- I understand that i must have comparable, employer-sponsored group medical and/or dental plan coverage in order to Opt-Out.
- I understand that until I report a change in my other health/dental coverage I will not be enrolled in the county's medical/dental plans.
- The County may verify or request additional information on the plans stated on this form at any time. In the event verification of my stated coverage above indicated that the coverage does not exist or I fail to timely provide the requested information, the County will revoke my Opt-Out election.
- **I am responsible for notifying the County within 60 days of loss or change in the employer's group medical and/or dental plan as stated on this form. Failure to report the loss or change within 60 days will result in denial of before tax payment of my premiums and dental of dependent coverage.**
- The County's acceptance of this election will be based on timely submission and adequate proof of comparable coverage. My failure to provide written change within 60 days will result in denial of my Opt-Out election.
- The County will determine the effective date of this Opt-Out election, in accordance with IRS Code Section 125, carrier contracts and the County's standard administrative practices.
- I am responsible for all retroactive premiums for coverage that may be required to insure the least amount or no break in medical and/or dental plan coverage. If a gap in coverage occurs, I will be personally liable for medical and/or dental claims and lack of coverage.
- I understand that by electing to opt out my Flexible Benefit Plan Dollars may change in accordance with the appropriate MOU.
- I hereby release and hold harmless San Bernardino County, its officers, agents and employees from any liability arising from the fact that a County-sponsored medical plan is not provided to me and I hereby waive any rights to be afforded such coverage.
- **I understand that I am not required to recertify at open enrollment. The County will maintain my Opt-Out status until I say otherwise.**

I certify under penalty of perjury that the information contained on this document is true and correct.

Employee Signature	Date

FORM MUST BE COMPLETED, SIGNED AND RETURNED TO YOUR PAYROLL SPECIALIST

Waiver Agreement

I understand, accept and agree to the following terms and conditions:

- I understand that if my spouse, domestic partner, or parent terminates employment, I will be required to enroll in a County-sponsored medical and/or dental plan(s) within 60 days of my spouse's/domestic partner's termination.
- I understand that by electing to waive my Flexible Benefit Plan Dollars may change in accordance with the appropriate MOU.

I certify under penalty of perjury that the information contained on this document is true and correct.

Employee Signature	Date

This document/form incorporates use of e-signature(s) in accordance with the San Bernardino County Policy #03-12 and Standard Practice 1.

FORM MUST BE COMPLETED, SIGNED AND RETURNED TO YOUR PAYROLL SPECIALIST

Payroll Specialist Name (Print and Sign)	Date Received

Office Use Only

☐ Approved	**Authorized Representative Signature**	**Date**
☐ Denied		

Effective Date	**Employee Covering Spouse**	
	☐ Spouse/domestic partner already enrolled (Medical)	☐ Spouse/domestic partner added to Medical
	☐ Spouse/domestic partner already enrolled (Dental)	☐ Spouse/domestic partner added to Dental
HR Comments		

Completed By (Employee ID)	**Date**	**Approved By** (Employee ID)	**Date**	**Keyed By** (Employee ID)	**Date**	**Audited By** (Employee ID)	**Date**

DISTRIBUTION: *Original - EBSD-HR (0440)*
Copy - Department of Spouse/Domestic Partner or Parent (for Waiver only)