Medical Declination Form

Please fill in information for all persons waiving medical coverage:

Employer **Solano Irrigation District**

Employee _____ SSN _____

Relationship	Name (Last, First)	SSN	I am covered under another **group** medical plan (check box)
Self			
Spouse			
Child			
Child			
Child			
Child			

Use a second sheet of paper if necessary.

Employees must be enrolled in another group health plan to waive coverage. Coverage under Covered California, the public Exchange, is not considered another group health plan. If coverage the other group health plan is lost, that constitutes a qualifying event to enroll in ACWA JPIA's plan the first of the month after the other coverage ends. The employee must make the request to enroll within 31 days of the loss of other coverage and provide proof of loss of this coverage. Otherwise, enrollment may not occur until the following Open Enrollment.

Dependents do **not** have to be enrolled in another medical plan to waive coverage. Dependents declining coverage, not covered by another group medical plan, may not enroll until Open Enrollment.

_____ _____ _____

Employee Name Employee Signature Date

Solano Irrigation District

Employer

Sally Donez-Lacy, Director of Human Resources

Employer Representative Name & Title

_____ _____

Employer Representative Signature Date