COLLEGE OF MARIN

F4-7A – UPM/AFT

Application for Waiver of District Medical Benefits

TEMPORARY CREDIT UNIT MEMBERS ELIGIBLE FOR KAISER MEDICAL COVERAGE

To: HUMAN RESOURCES

From _____

Employee

I wish to apply to the District for a waiver of my Kaiser medical benefit coverage and that of my dependents.

In applying for this waiver, I hereby certify and document with attached proof of coverage that I have comparable coverage under another plan.

I understand that in applying for this medical benefit waiver by October 1, I must accept the consequences of my decision which may include, but are not limited to:

(a) Changes in the law or insurance carrier procedures, which would preclude this option;
(b) Future changes in the District-offered medical benefits.

I understand that upon approval by the Human Resources Department, I will receive a $1500 annual payment, or prorata share which reflects the contract year (October 1 to October 1). I understand that I will receive one half of this waiver payment by December 15th with the balance being paid by check no later than March 15th of the following semester. **I further understand that I must reapply to Human Resources for this waiver by October 1 of each year, and provide the necessary proof of coverage**. To be reinstated to District Kaiser medical benefits, I must apply within 30 days of the start of the class or assignment during the Fall semester to the Human Resources Department.

Loss of Coverage:
In the event of loss of coverage under another plan, I understand that I may reinstate to District Kaiser medical benefits, but that I must apply within 31 days of the date of loss. I would then receive a prorata share of the $1500 annual payment which reflects that portion of the year that I waived medical benefits. (October 1 to October 1).

Employee Signature _____ Date _____

Human Resources _____ Date _____