SUBMIT FORM TO: Benefits Department
56 South Lincoln Street • Stockton, CA 95203
Office (209) 933-7026
Fax (209) 933-7011
Email: benefits@stocktonusd.net

Declaration of Health Coverage: HBD-12A Form

EMPLOYEE INFORMATION: *PRINT ALL REQUIRED INFORMATION*

Social Security Number	*Name (First)*	*Middle*	*Last*

ELECTION

- ❒ **I elect** to enroll myself only.
- ❒ **I elect** to enroll myself and all eligible dependents.
- ❒ **I elect** to enroll myself. My eligible have other health insurance coverage.

DECLINE

- ❒ **I decline/opt** out enrollment for myself and my eligible dependents because we have other health insurance coverage ***(evidence of other coverage is required)***
- ❒ I **decline/opt** out enrollment for myself and or my eligible family members for reasons other than having health insurance coverage

SUSD as a Plan Sponsor is required under Health Care Reform to offer Medical Health Coverage to ALL Employees who work 20 hours per week or more.

By signing the Medical Declaration of Health Coverage Form, I am stating that I agree and understand the conditions of this agreement.

If you or your dependents lose health insurance coverage, you can enroll in the CalPERS Health Benefits program. You must request enrollment within 60-days from the date you lose coverage.

If you do not request enrollment within 60-days, you or your dependents must wait until 90-days from date of request, or the next Open Enrollment period before you can enroll in the program. Your effective date of coverage will be the month following the 90-day waiting period or the Open Enrollment effective date.

_____ _____
Employee Signature Date

_____ _____
Benefits Department Staff Signature Date