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

Effective Date _____
Staff Initials _____
Bargaining Unit _____

MEDICAL COVERAGE WAIVER AND CASH IN LIEU PROGRAM

MY SIGNATURE BELOW HEREBY CONSTITUTES AND SERVES AS NOTIFICATION TO STOCKTON UNIFIED SCHOOL DISTRICT THAT I AM WAIVING THE MEDICAL AND CHIROPRACTIC INSURANCE COVERAGE BY SUSD, WHICH WAS PRESENTED TO ME ON DATE: _____/_____/_____

FURTHERMORE, I AGREE AND UNDERSTAND THAT I AM SOLELY RESPONSIBLE FOR SECURING MEDICAL COVERAGE FROM ANOTHER PROVIDER, AND I AGREE TO HOLD HARMLESS SUSD FOR ANY PERSONAL LOSSES INCURRED THAT WOULD HAVE BEEN COVERED UNDER THE DISTRICT'S MEDICAL PLANS.

ELIGIBILITY FOR THE CASH IN LIEU OF HEALTHCARE BENEFITS PROGRAM "REQUIRES" ONE OF THE FOLLOWING DOCUMENTS:

1. **Evidence of other Health Coverage Documentation** - copy of Health Insurance Card listing your name as an enrollee and the coverage begin date is acceptable.

2. **Written Statement** from a Spouse/Partner, Parent/Guardian's Employer (must be on letterhead) or Benefit Provider confirming current health insurance and that you are an active enrollee.

   District Employees will need to provide option #1

FAILURE TO NOTIFY THE DISTRICT OF YOUR LOSS OF COVERAGE WILL RESULT IN THE REPAYMENT OF ALL CASH IN LIEU PROCEEDS RECEIVED FROM THE DATE OF THE LOSS OF COVERAGE.

I agree and understand that by not providing one of the above documents to the Benefits Office at time of enrollment that I will not be eligible for the Cash In Lieu program until documentation is provided.

_____ _____
Employee Name *(Please Print)* Employee ID#

_____
Social Security Number

_____ _____
Employee Signature **Date**