Liberty Union High School District
20 Oak Street
Brentwood, CA 94513
(925) 634-2166
FAX (925) 634-1687

WAIVER OF OFFER OF MEDICAL COVERAGE 2025

Please sign, date and return this form along with the required documentation to the Payroll Department

EMPLOYEE NAME (Please print or type legibly)	DEPARTMENT	PHONE #

As required by the Patient Protection and Affordable Care Act (ACA), you are being given the opportunity to enroll in medical health coverage offered by the Liberty Union High School District. You have the right to decline, or waive coverage. If you waive coverage for you and/or your dependents under the Liberty Union High School District's medical health plan, you are required to show that you have medical health coverage through another source by providing proof of coverage (*Explanation of Benefits letter*) **or** by having the certificate below completed.

The following may apply if you decide to waive coverage:

- If you waive this coverage and do not obtain coverage on your own, you could be subject to a penalty under the individual responsibility requirement of the ACA and will not qualify for government subsidies to purchase individual health insurance on the Marketplace.
- If you waive coverage, you will only be allowed to enroll in the District's medical health plan if you have a qualifying event (e.g. marriage, divorce, birth/adoption, loss of coverage, or change in job status). You must request to enroll in the plan within 60 days of the qualifying event.

I have read the above and understand the consequences of my waiver of coverage. I attest that I was offered and am eligible to enroll in a health plan that is affordable, minimum value, as defined under the ACA, through the Liberty Union High School District for the period from **January 1, 2025 to December 31, 2025** and I have decided to waive the medical coverage because I am enrolled in other **employer**, non-individual market health plan coverage*. I agree to provide proof of coverage on an annual basis. In the event that I lose my alternative health coverage at any time throughout the calendar year, I agree that I will immediately notify Human Resources to enroll in the CalPERS health plan.

_____ _____

Employee's Signature **Date**

*Non-individual market health coverage includes other employer-sponsored plans, Tricare, Medicare and Medi-Cal.

Certification of Other Coverage

(To be completed by employer providing alternate health coverage)

This is to certify that _____ is currently insured by

Name of Employee Listed Above

_____ in the following manner:

Medical Insurance Plan Name

_____ _____ _____

Name of Insured **Relationship** **Effective Date of Coverage**

_____ _____ _____

Signature of Benefit Officer **Date of Signature** **Phone Number**

_____ _____

Title **Agency/Company Name**

VERIFICATION (PAYROLL Use Only)

_____ _____ _____

PARYROLL Representative's Signature **Printed Name** **Date Received**