County of Mendocino
Health Insurance Declination Form

Under the Affordable Care Act, the County of Mendocino intends to offer affordable minimum essential coverage to full-time, part-time and extra help employees who average 30 hours of service or more per week during a specific "look back" period measured over one year. Employees are permitted to decline enrollment in the Health Plan under the conditions listed below. After reading this document, if you wish to decline coverage, please sign and date this Health Insurance Declination Form and return it and all required documentation to Human Resources.

By declining coverage in the County's health plan, I am aware of the specific guidelines that I agree to as follows;

Although I am not required to enroll in the County of Mendocino Health Plan (the "Health Plan"), I understand that I must complete this declination form in order to waive the coverage offered to me. My failure to complete and return this form to Human Resources will result in a default election to be automatically enrolled in the Health Plan, Plan 2.

I hereby acknowledge I have been given an effective opportunity to enroll in health coverage offered by the County of Mendocino and the coverage offered meets the standards of affordability and minimum value coverage as defined by the Affordable Care Act. I further understand that I can return to the Health Plan in two specific situations only;

1. Subject to Health Plan rules, if I experience a qualifying life event or,
2. During the Plan's open enrollment period.

I waive coverage for myself and my eligible tax dependents, including my spouse, and attest that all will have other minimum essential coverage for the period from _____ to _____ through the carrier _____ and the coverage is:

☐ Other employer-sponsored group coverage (e.g., through a spouse or domestic partner)
☐ TRICARE ☐ Medicare
☐ Medi-Cal ☐ COBRA

I understand and agree that because I am electing not to enroll in the County Health Plan, I am not eligible for the County paid air ambulance membership.

By signing below, I hereby decline coverage under the Health Plan and certify that I have coverage under another group health plan. In addition, I agree to provide verification of enrollment to the Executive Office - Health Benefits Administration.

Employee Signature: _____

Printed Name:_____