Health Insurance Waiver Form

LONG BEACH CITY COLLEGE

LONG BEACH CITY COLLEGE DISTRICT

Health Insurance Waiver of Benefits
For the period of July 1, _____ – June 30, _____

I, as an employee of Long Beach City College, am choosing the following option for waiving all or part of the health insurances offered to me:

*Please **initial** on the line that precedes the type of coverage(s) you are declining.*

_____ **I choose to waive ALL insurances** offered to me (and my dependents) at this time –no Health & Welfare coverage (medical, dental, vision and Employee Assistance Plan (EAP)).

_____ **I choose to waive MEDICAL insurance** for myself (and my dependents). However, I will be keeping all other insurances (dental, vision, and Employee Assistance Plan (EAP)) for myself and my dependents.

_____ **I choose to waive my DENTAL and VISION insurance** for myself (and my dependents). However I will be keeping only medical and the Employee Assistance Plan (EAP) for myself (and my dependents).

Name(s) of person(s) being removed from coverage:

_____ _____

_____ _____

_____ _____

I acknowledge that I have been offered group health coverage by my employer, Long Beach City College District. I acknowledge by signing below that I am waiving the above listed coverage(s) and will not be allowed to (re)enroll during the program plan year unless:

- I experience a qualifying event (i.e. marriage, childbirth, adoption, etc.), or
- I re-enroll at the next district open enrollment period

I understand that **my choice to waive coverage must be renewed at each open enrollment** by completing a new waiver form.

MANDATORY FORM: I understand that if I **waive ALL insurances** offered to me, **I must still complete a mandatory enrollment form** for the Basic Life and AD&D coverage provided by the LBCCD.

Print Name	Last Four of Social Security #	Employee ID #
Employee's Signature		Date

Benefits Office | Phone: (562) 938-4531 | Fax: (562) 938-4959