PALOMAR COLLEGE
Learning for Success

Human Resource Services

Voluntary Opt-Out of District Health Coverage

New Employee

*Please read, sign, date, and return this form to HRS no later than **30 days** from your hire date if you wish to opt-out of District Health Coverage for the 2016 calendar year, ending on December 31, 2016 only.*

Employee Name_____ Date _____

Social Security #_____ or Employee ID # _____

Name of Alternate Health Insurance Coverage _____

Subscriber's relationship to you _____

You must attach written documentation of your other coverage on employer or group letterhead signed by an authorized representative of the employer or health insurance group providing the alternative coverage. Your completed form and written documentation must be received by the open enrollment deadline to receive the opt-out payment.

- I hereby acknowledge that I have been advised of my right to have health insurance coverage through Palomar Community College District. Having been so advised. I do hereby elect to opt-out of health insurance coverage through the District.
- I understand that this election is for the period of January 1, 2016 through December 31, 2016 only. I must re-elect to opt-out annually during the District's Open Enrollment period.
- In return for my agreement to opt-out of health insurance coverage, the District agrees to pay me $200 monthly, not to exceed $2,400 annually.
- I hereby certify that there is no outstanding court order or agreement requiring me to provide health insurance coverage for my spouse and/or dependent children, if any.
- I hereby acknowledge that I may only obtain health insurance through the District in the future, other than during the open enrollment period, if my alternate health insurance coverage is canceled or otherwise terminated and I provide documentation of such event to the District's Benefits Specialist within thirty (30) days of the cancellation of coverage.
- I understand that the opt-out payment is considered ordinary income and subject to applicable state and federal tax.

_____ _____

Employee Signature Date

PLEASE RETURN THE ORIGINAL SIGNED FORM AND DOCUMENTATION OF OTHER COVERAGE TO HUMAN RESOURCE SERVICES