

# Health Insurance Waiver Form For 2016



## LONG BEACH CITY COLLEGE DISTRICT Health Insurance Waiver of Benefits For the period of July 1, 2016 – June 30, 2017

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 (health, dental, vision, and behavioral health).

\_\_\_\_\_ I choose to waive **MEDICAL insurance** for myself (and my dependents). However, I will be keeping all other insurances (dental, vision, and behavioral health) 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 behavioral health insurance 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

\_\_\_\_\_  
Social Security #

\_\_\_\_\_  
Employee ID #

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date