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COLLEGE OF MARIN

UPM/MARIN CCD FORM F4.A

Temporary Credit Unit Members' Application For Waiver of District Medical Benefits

To: Benefits Office

From: _____
Print name

I wish to apply to the District for a waiver of the District's medical benefit coverage and that of my dependents and its contribution to the medical benefit coverage. In applying for this waiver, **I hereby certify and document with attached proof of coverage that I have comparable coverage under another plan**.

I understand that in applying for this waiver of the District's medical benefit and its contribution to my medical benefit, I must accept the consequences of my decision, which may include, but are not limited to:

a) My subsequent loss of the other medical coverage for any reason;
b) The time which will elapse before I may obtain District coverage;
c) Changes in the law or insurance carrier procedures, including but not limited to those which would preclude this option;
d) Future changes in the District-offered medical benefits and eligibility requirements

Pursuant to Article 4, I understand that if the Benefits Office approves my application for a waiver, I will receive an annual payment of $1500, or prorated share which reflects the contract year (October 1 to September 30). I understand that I will receive one half of this waiver payment by December 15 with the balance being paid no later than March 15 or April 15 (for unit members with late start classes) of the following semester if I remain eligible for the waiver in that Spring semester. I further understand that I must reapply for this waiver by October 1 of each year, and provide the necessary proof of coverage. To obtain the District contribution for medical benefits, I must apply when permitted to do so by the insurance carrier (e.g., upon a mid-year qualifying event or during open enrollment) if I am eligible for benefits at that time. If I reinstate to District medical benefits as allowed by the carrier, I understand that I would receive a pro-rata share of the annual payment which reflects the portion of the year for which I waived medical benefits.

Employee Signature _____ Date:_____

For Benefits Office Use Only:

Benefits Office Signature _____