SAN MARCOS
UNIFIED SCHOOL DISTRICT
engaging students...inspiring futures

Employee Waiver of Medical Benefits
2020 Health Benefit Plan Year

I _____ understand that by signing this waiver, I am declining coverage of the medical plan offered by San Marcos Unified School District beginning effective date: ***January 1, 2020***. I am waiving my medical benefits because I have medical coverage through _____ policy number _____ and will maintain active coverage under this plan.

Should I lose coverage in the above named plan, I understand that I must immediately enroll back in the San Marcos Unified School District's medical plan. I understand that I will have 30 days from the loss of the above named plan to enroll back in the San Marcos Unified School District's medical plan.

I understand that I must provide proof of my other medical coverage and I have attached the required documentation (e.g. copy of health insurance ID card or letter from employer providing the other coverage).

Employee Signature _____
Dated _____

Verified by District Representative _____
Dated _____