COUNTY OF COLUSA
DENTAL PLAN COVERAGE WAIVER FORM

The County of Colusa requires its employees to enroll in County-sponsored dental coverage unless they can show proof of alternative coverage from another source. In order to qualify for cash in-lieu benefits, this proof of alternative coverage must be provided during the employee's initial eligibility period and annually during Open Enrollment. The amount of the cash in-lieu benefit depends on the employee's benefits resolution or memorandum of understanding and is available for employees hired before January 1, 2013.

This waiver form is to be used by an employee who wishes to waive County provided dental coverage and can provide proof of alternative coverage from another source. Please complete this form and submit it along with confirmation of existing coverage to the Human Resources Department. **This form along with proof of coverage will be required annually.**

EMPLOYEE INFORMATION:

____________________________________ ____________________________________
Last Name First Name

____________________________________ ______________________ _________
Mailing Address City Zip Code

EXISTING DENTAL COVERAGE INFORMATION:

I have existing dental coverage and wish to waive the County provided dental plan coverage. **<u>Proof of coverage that states employee's name must be attached.</u>**

____
Subscriber's Name

______________________________ _________________
Group No. ID No(s).

PLEASE READ THE FOLLOWING BEFORE SIGNING THIS FORM:
I wish to decline the County provided dental plan coverage. I acknowledge that as a result of this waiver, I forfeit all rights to coverage otherwise available to me under the County dental plan. I realize that I will not be able to enroll in a County dental plan option until the next Open Enrollment period. If I cease to be covered by my existing plan outside of Open Enrollment, I must provide proof that my other dental coverage has ended and enroll in the County dental plan coverage within 60 days of the qualifying event.

I understand that the information provided above is a requirement if I want to waive the County dental plan coverage. I certify that all the information provided by me herein is accurate. I understand that it is solely my responsibility to ensure that the Human Resources Department has received and approved my waiver application. I understand that the waiver form and proof of dental coverage will be required annually to qualify for the waiver, and that if I do not provide the required documentation I will not receive the cash in-lieu benefit and will be enrolled in the County-sponsored dental plan at the employee only level.

_________________________________ ________________________________ ____________
Employee signature Print Name Date

Human Resources Office Use Only: Processing Date: ____________________ Processed By: __________________________

Eligible for cash in-lieu: □ Yes (DOH pre 1/1/2013) □ No (DOH post 12/31/12)

COUNTY OF COLUSA
DENTAL PLAN COVERAGE WAIVER FACTS

Qualification:

In order to qualify for a County dental plan coverage waiver, an employee must demonstrate that he/she has alternative coverage from another source. Evidence of such coverage must be provided by the employee.

Annual Recertification:

Employees receiving the dental plan coverage waiver must recertify annually during the County's Open Enrollment period. Recertification consists of the completion of the appropriate County forms and evidence of coverage. If the required documentation is not received during this period, the waiver and cash in-lieu benefits will be discontinued and the employee will be enrolled in the County-sponsored dental plan at the employee only level effective January 1.

Notice of Enrollment Rights:

This waiver of coverage must be completed during your initial eligibility period or during Open Enrollment. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 60 days after the marriage, birth, adoption or placement for adoption.

You may also be eligible to enroll in a County dental plan if your other health coverage terminates as a result of any of the following:

- Termination of employment;
- Change in employment status;
- Employer no longer offers dental plan coverage;
- Employer ceases premium contribution toward coverage;
- Divorce, legal separation, or death of the person (subscriber) through whom you (or your family members) are covered as a dependent; or
- Exhaustion of COBRA continuation of coverage.

DOCUMENTATION VERIFYING ALL CHANGES LISTED ABOVE WILL BE REQUIRED.