Desert Sands Unified School District
47-950 Dune Palms Road ♦ La Quinta, California 92253 ♦ (760) 777-4200

Declination of Coverage - Waiver of Benefits

If you are a full-time employee, you are required to enroll in the medical health plan.

If you are not full-time and wish to decline coverage, please check the appropriate box:

☐ I am a tandem teacher and teaching less than full-time. Per my Tandem Teaching Agreement, I have waived my medical, dental and vision benefits.

☐ I am a part-time classified or management employee and wish to decline the medical coverage.

☐ I am a part-time certificated employee and wish to decline the medical coverage.

If you are full-time and wish to decline dental and/or vision coverage, please check the box below:

☐ I am a full-time certificated employee and wish to decline the dental and/or vision coverage.

Initial the line(s) of coverage you are declining:

_____ I am declining Medical coverage effective _____.
_____ I am declining Dental coverage effective _____.
_____ I am declining Vision coverage effective _____.

I acknowledge by signing below that I am declining the above listed coverage(s) and will not be allowed to (re)enroll during the program plan year unless:

1) I experience a qualifying event, or,
2) I re-enroll at the next district open enrollment period for these plans or
3) I have an employee status increase in employment hours with the district. This has to be a 25% or more increase in the employee/employer contribution to the benefit package.

I understand that as of January 14, 2014, I am required by the Affordable Care Act to maintain an acceptable level of health insurance coverage for myself and my dependents. If I do not have coverage that satisfies my individual responsibility under the Affordable Care Act, I may be assessed a tax penalty for failure to obtain coverage.

The coverage being offered to you by Desert Sands USD satisfies its obligations under the Affordable Care Act. In particular, it is believed the health plan is affordable and exceeds Minimum Essential Coverage and Minimum Actuarial Value.

I have read the above information and acknowledge that I am declining the initialed line(s) of coverage.

_____ _____
Print Name Date

_____ _____
Signature Employee # or last four of Social Security #

_____
E-mail address (personal preferred)

/benefits/forms/17-18 Letters/2017-2018 Declination of Coverage