Department of Personnel Services

Employee Benefits Office
Dave Comerchero,
Employee Benefits Manager

County of Sacramento

Waiver of Employer-Sponsored Health Coverage Affidavit 2021

I hereby acknowledge I am currently waiving my County of Sacramento/Special District medical coverage and have been given an effective opportunity to enroll in the medical coverage offered by County of Sacramento/Special District for the plan year 2021.

I understand that the medical coverage offered to me by the County of Sacramento/Special District is for myself as an employee, as well as my qualified tax dependents (if any), and that the coverage meets the standards of affordable, minimum value coverage as defined by the Affordable Care Act.

I waive coverage for myself and my eligible tax dependents, including my spouse, and attest that all will have other minimum essential coverage for the plan year 2021 and the coverage is:

☐ Other employer-sponsored group coverage (e.g., through a spouse or domestic partner)
☐ TRICARE ☐ Medicare
☐ Medi-Cal ☐ COBRA

I understand other minimum essential coverage cannot include coverage purchased on the individual market, including through Covered California. Individuals waiving affordable, minimum value employer-sponsored coverage may not be eligible for premium tax credits or cost-sharing subsidies from Covered California.

This waiver affidavit is for the upcoming plan year 2021 and may only be changed during the annual open enrollment period or in the case of a mid-year qualifying event. I may be able to enroll myself (and my eligible dependents) if I/we experience a mid-year qualifying event and are no longer eligible for the other minimum essential coverage or if I have a newly eligible dependent as a result of marriage, birth or adoption.

I understand that I must request enrollment within 30 days after losing other minimum essential coverage or after the date of marriage, birth or adoption. If I do not do so, I will not be able to enroll until the next annual open enrollment period.

Note: Failure to return this affidavit before the start of the 2021 calendar year and to maintain other group sponsored minimum essential coverage will suspend eligibility for any Cashback or PSI!

By signing below, I certify I have read this form and understand the consequences of waiving my employer provided medical coverage. I also certify that the information I have provided is true and correct to the best of my knowledge.

_____ _____
Signature of Employee **Date**

_____ _____
Print Name **Employee Number/SSN**

Please return to your District Human Services Department.