Department of Personnel Services

Employee Benefits Office

County of Sacramento

Waiver of Employer-Sponsored Health Coverage Affidavit 2024

I hereby acknowledge I am currently waiving my County of Sacramento medical coverage and have been given an effective opportunity to enroll in the medical coverage offered by County of Sacramento for the plan year 2024.

I understand that the medical coverage offered to me by the County of Sacramento is for myself as an employee, as well as my qualified 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 any dependents, and attest that all will have other minimum essential coverage for the plan year 2024 and that 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 2024 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: This form is due by December 31, 2023. Failure to return this affidavit before the start of the 2024 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/PIN**

Return by fax at 916-874-4621 or scan and email to MyBenefits@saccounty.gov