



CITY OF SAN ANTONIO Waiver of Health Coverage Form

WAIVER OF HEALTH BENEFITS – I decline the health benefits provided by the City of San Antonio.

Opt Out – I elect to waive coverage under the City of San Antonio Medical Plan for the 2011 benefit year.

I understand that if I decline enrollment now and have no other health insurance coverage, I will be liable for any and all health care liabilities incurred due to this lapse in coverage.

Please provide name of carrier and policy number if you opted out of the City's health insurance.

Carrier Name: _____

Employer/Group: _____

Policy Name/Number: _____

I understand that once an employee has waived coverage, no changes can be made during the year until the next annual open enrollment period, unless there is a **legal change in family status**.

If there is a legal change in family status, the employee may add or drop dependent coverage. A **legal change in family status** would allow the employee to change the coverage level of the medical, dental, and vision plans, and allow changes to their Health Care and/or Dependent Care Reimbursement accounts. Employees have 31 calendar days to notify the Human Resources Department to make the change. **If the change is not requested within 31 days of the legal change of status, the change cannot be made until the next open enrollment period.** Legal documentation is required with any change request. A legal change in family status includes: divorce, marriage, death, birth or adoption of a child, change in employment status of the employee's spouse, or ineligibility of a child due to age or change in student status.

Employee Signature: _____

Employee Name (Print): _____

SAP#: _____ Date: _____