Pasadena Area Community College District - Full-Time Employees

Complete every line, sign and date if you are not enrolled in the District's sponsored health plan (Full-Time Employee's) and have insurance coverage elsewhere. Forms are invalid if not complete and do not include a copy of current insurance card.

All employees currently enrolled in "opt-out/cash-in-lieu" are being offered group health coverage for the upcoming benefit year and that they must choose to enroll in an offered health plan or opt-out (cash-in-lieu) during 2019 open enrollment.

Opt Out – Refusal of Personal Coverage (Cash-in-Lieu)

SSN: ______________________ Date of Birth (mo/day/year): ______________________

Last Name: ______________________ First Name: ______________________ M.I. ______

Employer (Group) Name: Pasadena Area Community College District

I am refusing Pasadena Area Community College District Health Plan Coverage for the following:

Myself: ______________________ Name of person carrying your coverage now, or Self? ______________________

Number of dependents: ______________ Their place of employment (if applicable): ______________________

When you used the District's Insurance Plan, whom did you cover? List below

Relation	Last Name	First Name	M.I.	Date of Birth (mo/day/year)	SSN
Self					
Spouse					
☐ Son ☐ Daughter					
☐ Son ☐ Daughter					
☐ Son ☐ Daughter					
☐ Son ☐ Daughter					
☐ Son ☐ Daughter					

I hereby acknowledge I have been given an effective opportunity to enroll in health coverage offered by the Pasadena Area Community College District for the plan year from October 1, 2019 to September 30, 2020 and the coverage offered 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 are covered under another employer's group health plan for the period from ______________ to ______________.

If the individual(s) shown above involuntarily lose coverage under another the employer's health benefit plan, I acknowledge that I may request enrollment in the Pasadena Area Community College District health plan by applying for coverage within 30 days of the loss of coverage.

Otherwise, I acknowledge that my employer's health plan may exclude coverage for myself and any dependents until the next open enrollment period or qualifying event.

Name of other health benefit plan: ______________________ ☐ HMO ☐ PPO

______________________________ Signature of Employee ______________ Date

______________________________ Signature of Employer ______________ Date