



## City of Alameda • California

# 2021 Health Insurance Waiver Form

Under the current Patient Protection and Affordable Care Act regulations, the City of Alameda is required to offer affordable health insurance coverage options to employees who are hired to work an average 30 hours per week.

If you are eligible for coverage but elect to opt out, you are required to show proof annually that you have health coverage through another source. Proof of coverage or completion of the certification below by a Benefit Officer of the contracting company or organization is required.

If you elect to opt out of the City's health plan, please sign, date, and return this form to the Human Resources Department, along with the required documentation no later than 30 days from your date of hire or eligibility for other coverage.

Employee Name \_\_\_\_\_  
Title \_\_\_\_\_  
Department \_\_\_\_\_

I understand that I am eligible to enroll in a health plan offered by the City of Alameda. I wish to waive enrollment and agree to provide proof of coverage on an annual basis. In the event that I lose my alternative health coverage at any time throughout the calendar year, I agree that I will immediately notify the Human Resources Department to enroll in the health coverage through CalPERS.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

Certification of Other Coverage (To be completed by agency providing alternate health coverage)		
This is to certify that _____ is currently insured by (Name of Employee)		
_____ in the following manner: (Medical Insurance Plan Name)		
_____ (Name of Insured Sponsored)	_____ (Relationship)	_____ (Effective Date of Coverage)
_____ (Signature of Benefit Officer)	_____ (Date of Signature)	_____ (Telephone Number)
_____ (Title)	_____ (Agency/Business Name)	

*Human Resources Department  
2263 Santa Clara Avenue, Room 290  
Alameda, CA 94501  
(510) 747-4900*