ALTERNATE BENEFIT ENROLLMENT FORM

(Please Complete All Information - Print or Type)

EMPLOYEE'S NAME: _____
Last First Middle Initial

Social Security #: _____ **DOH:** _____

WAIVER OF COVERAGE

I decline coverage for:

☐ **Myself -** (If you decline coverage for yourself, you automatically decline coverage for any eligible dependents.)

I am declining coverage because I am currently covered under another employer-sponsored health plan.

Who is the employee/subscriber providing the other plan? _____

Name of the employer sponsoring the other health plan: _____

Name of the carrier the other coverage is with: _____

ENROLLMENT FORM

I wish to enroll in the City of Rohnert Park's Alternate Benefit Program. I understand that I am waiving my health insurance coverage offered by the City of Rohnert Park for both myself and any eligible dependents. I further understand that I may only obtain health insurance coverage through the City of Rohnert Park's program during the open enrollment period or during the period prior to open enrollment if the coverage described above through another employer-sponsored health care plan terminates as a result of any of the following:

-Termination of employment.
-Change in employment status.
-Termination of the other plan's coverage (i.e., the group no longer offers a health plan).
-Cessation of the other employer's contribution toward coverage.
-Divorce or death of the person through whom I am covered as a dependent.

I understand that I am entitled to receive a monthly Alternate Benefit Amount as defined in the current Memorandum of Agreement (MOA) or Outline of Benefits for my employee unit. This amount is not compensation, but a benefit and has to be directed to an employee's deferred compensation account, CalPERS service credit, or for the purchase of supplemental life insurance and/or any other eligible benefit program approved and authorized by the City.

ALTERNATE BENEFIT APPLIED TO THE FOLLOWING:

☐*Deferred Compensation Account* – *Note that the Alternate Benefit counts towards the Deferred Compensation Calendar-Year Maximum*

☐*Nationwide* ☐*MissionSquare*

☐*CalPERS Repayment*

☐*Supplemental Life Insurance*

CURRENT BENEFIT AMOUNT: $400.00 **Effective:** _____

By: _____ Date: _____
Employee's Signature

_____ Date: _____
Human Resources Representative's Signature

c: Employee
Payroll