ELECTION OF CASH IN-LIEU OF BENEFITS
PARTICIPATION IN THE GROUP MEDICAL AND DENTAL INSURANCE

Return this form and attachments to PCCD Benefits Office, 333 East 8th Street; Oakland, Ca 94606 along with your verification of other group insurance coverage within 30 days of eligibility. Eligibility criteria for the cash-in-lieu (CIL) of benefits plan is based on the collective bargaining agreement covering employment with Peralta and is subject to post enrollment audit. *In general, this CIL benefit is available to active employees, including contract faculty, and benefit-eligible employees in unions PFT, Local 39, SEIU 1021, managers, and confidential employees.*
Temporary employees and/or hourly part-time non-contract faculty are ineligible for this CIL benefit.

I hereby waive enrollment into the following group insurance plans, which I am otherwise eligible for based on my own employment eligibility with Peralta Community College District.

Section A-Waiver/Election

I am waiving (**initial as applicable**)

_____Peralta Group Medical Plan Enrollment; I am therefore eligible for cash benefits of $225/month

_____Peralta Group Dental Plan Enrollment; I am therefore eligible for cash benefit of $25/month

Section B-Affirmations/Verifications:

I affirm that my tax dependents and/or I, are covered by another medical and/or dental plan that is not individual market coverage, and attaching dated verification of my current coverage offered through:

_____ _____

(Name of Medical Carrier/Plan Administrator) (Name of Dental Carrier/Plan Administrator)

Initial:

_____ I understand that the verification must include group identification number, effective date of coverage information for each. I understand that Peralta Community College District reserves the right to verify this coverage.

Initial:

_____I have tax dependents (I am attaching coverage verification for all tax dependents) _____I do not have dependents

Section C-Cash Options/ Acknowledgements:

Based on the waiver options indicated above, I am eligible for cash in the amount of:

Initial:

_____ $225 to be received on a monthly basis as a taxable benefit in-lieu of individual participation in a Peralta Community College District group medical plan.

Initial:

_____ $25 to be received on a monthly basis as a taxable benefit in- lieu of individual participation in a Peralta Community College District group dental plan.

Section D-Other Considerations & Disclosures:

My signature below affirms my understanding of, and compliance with, the statements below:

1. I cannot opt for cash if my only other medical insurance is stand alone Medicare, TriCare, Medi-Cal, COBRA or an individual plan.
2. Under no circumstances will the cash benefit be made retroactive beyond 30 days.
3. Participation in the cash-in-lieu of benefits plan is voluntary.
4. If I wish to enroll in any of Peralta Community College District's group medical or dental plans at a later date, I will be subject to that plan's enrollment rules and benefit plan design in effect at that time.
5. It is my responsibility to complete the Peralta Benefits Enrollment form and submit documentation within 30 days of loss of coverage under another group plan to re-enroll in a Peralta benefit plan at a future date as required by the Health Insurance Portability and Accountability Act (HIPPA) of 1996. Other events which permit me to rescind this waiver are noted below: Marriage, Divorce, Legal Separation, Birth, Adoption, Death, Termination of employment (unit member or eligible dependents); exhaustion of COBRA, individual no longer resides or works in HMO service area, individual ceases to be a dependent, plan terminates a benefit plan option, involuntary loss of coverage under another group plan, Children's Health Insurance Plan/ Medicaid (Medi-Cal) Rule; meeting or exceeding a plans lifetime maximum on all benefits.

Name (please print) Signature Date

Social Security Number Date of Birth Peralta Employee ID

Benefit Program PFF/PTC/PRA/PRB/ Date of Benefits Office Approval Payroll Effective