Certification Form for Waiving Health Plan Coverage

Employee Name: _____ ID #: _____

☐ Medical Plan

I elect not to enroll in medical insurance through the County for the 2024 Plan Year. I certify that I and all of my tax dependents have other group medical insurance coverage that provides minimum value within the meaning of the Affordable Care Act. I understand that this certification will be required for every Plan Year for which I waive the County's medical insurance coverage.
Employee Initials: _____

My outside plan is:

- ☐ My spouse's employer's group medical insurance plan
- ☐ My parent's employer's group medical insurance plan
- ☐ Other group medical insurance plan

Name of outside plan:_____ Group #:_____ Effective Date:_____

☐ Dental Plan

Name of outside plan:_____ Group #:_____ Effective Date:_____

☐ Vision Plan

Name of outside plan:_____ Group #:_____ Effective Date:_____

☐ I have attached proof of other coverage ***for each type of insurance for which I am requesting a waiver***, in the form of a membership card, or letter from the applicable employer.

I understand that if I lose enrollment in my outside plan, I must notify Human Resources within 30 days of that loss, and I must immediately enroll in Tuolumne County plans. **Employee Initials:** _____

Employee Signature: _____ Date: _____

Human Resources (209)533-5566
Fax (209)533-5901