CITY OF WEST HOLLWOOD GROUP HEALTH PLAN

Employee Waiver Form

Employee Name (please print): ____

Plan Year (or other period of coverage): 2024 PLAN YEAR

I understand that I am eligible to enroll myself, and my spouse or registered domestic partner (if any), and my children (if any) for medical, dental, and/or vision care coverage under the plan for the plan year (or other period of coverage) specified above.

I hereby waive coverage under the plan for the plan year (or other period of coverage) specified above with respect to the following benefit:

_______ Medical coverage

Important: An employee who waives medical coverage under the plan is entitled to receive an opt-out payment as taxable compensation, as long as (1) the employee certifies that the employee and expected tax family (i.e. all other individuals for whom the employee reasonably expects to claim a personal exemption deduction for the taxable year to which the opt-out arrangement applies) will have minimum essential coverage – ***other than coverage in the individual market****, whether or not obtained through an insurance marketplace – during the plan year (or other period of coverage); and (2) the employee provides whatever additional evidence of alternative coverage that may be requested by the employer.*

I hereby certify that I and my expected tax family (as defined above) will have minimum essential coverage from the following source(s) for the plan year (or other period of coverage) specified above, and that this coverage is not from the individual market (check one or more):

_______ Spouse's employer _______ Medicare _______ Medicaid (including Medi-Cal)

_______ Tricare _______ Veterans' program _______ Prior employer

_______ Other (provide details:____)

I hereby agree that I will provide whatever additional evidence of alternative coverage that may be requested by my employer.

Important: An employee who waives coverage under the plan may revoke the waiver during the plan year (or other period of coverage) and become covered under the plan without waiting until the start of the next plan year, if the employee experiences a qualifying status change (such as marriage, divorce, birth of a child, a spouse's commencement or termination of employment, and certain other events), provided that the employee contacts the employer within 60 days after the date of the qualifying status change. Refer to the plan description and other enrollment materials for additional details.

Employee Signature:_________________________________ Date:______________