CITY OF OXNARD
HUMAN RESOURCES DEPARTMENT
MEDICAL PLAN DECLINATION OF COVERAGE

This form is required if waiving coverage under the City's medical plan[1]

Reason for Waiving Coverage: (check one)

☐ Covered by another employer-provided group medical plan
☐ Enrolled in Medicare
☐ Receiving Medi-Cal
☐ Covered by an Individual Medical Plan
☐ Other (explain)
____
____

I agree to the following:

- I understand that insurance coverage has been offered to me and my dependents by the City of Oxnard.
- I understand that I will not be eligible for a subsidy through the exchange since the City of Oxnard offers affordable coverage.
- I decline to participate in medical coverage at this time. I understand that if I decide to enroll at a later date, I will have to wait until the next open enrollment period unless I experience a qualifying event as defined by the Internal Revenue Code (IRC).
- I understand that I must provide **written proof of other employer-sponsored group medical insurance (as described below)** as well as this completed form to the Human Resources Department.
- I verify that by electing not to participate in the City Oxnard's medical insurance plan, it does not constitute a violation of any court order or legal obligation that I may be subject to.

I have read and understand the above conditions and procedures for opting out of the City's medical insurance plan.

Print Name:____________________________ Signature:____________________________

Date: _________________________________

ATTACH A COPY OF YOUR CURRENT VALID MEDICAL CARD WITH THIS COMPLETED FORM.

Benefits Use Only

____________________________	______________________	______________________
Benefits Representative	Date Received	Date Entered

[1] Existing employees may elect to opt out during Open Enrollment or a Qualifying Event as defined by the Internal Revenue Code (see the City of Oxnard Benefits Guide for more information).