CHIEF EXECUTIVE OFFICE
Human Relations Division
Employee Benefits

1010 10TH Street, Suite 5900, Modesto, CA 95354
Phone: 209.525.5717 Fax: 209.525.5779
countybenefits@stancounty.com

2022 Stanislaus County Proof of Other Coverage Form

You elected to waive your Stanislaus County medical plan coverage for the 2022 Plan Year, effective January 1, 2022. In order to receive the standard medical waive credit, you must enroll in a non-County qualified medical insurance program group coverage, meeting minimum standards under the ACA and you must provide us with proof of your other medical coverage.

Please complete and sign this form, and attach documentation showing proof of your other medical plan coverage. Documentation must include the effective date of coverage and list the Stanislaus County employee who is covered. Proof can be a letter from the employer or health carrier providing the coverage with a copy of a detailed confirmation statement, or a copy of your medical plan ID card.

Submit this completed form along with the supporting documentation via fax to 209-525-5779 or via e-mail to countybenefits@stancounty.com no later than 5:00 pm, Friday, November 12, 2021.

1. Employee Information

Last Name:	First Name:	Middle Initial:	ID #:	
Home Address:	City:		State:	Zip Code:
Home Phone:	Cell Phone:	Department:		

2. Other Medical Plan Coverage

☐ I have other medical insurance coverage. ☐ I have attached a copy of my proof of other coverage.

☐ My spouse/parent works for the County and has covered me as a dependent.
Spouse/Parent Name: Dept.:

Complete the information below **and** attach documentation as described above:

Name of Other Insurance Carrier/Medical Plan	Medical ID Number	Effective Date	Employer

3. Acceptance Agreement – Please read the following and acknowledge by signing below

I understand that I am freely waiving the right to participate in the County's medical plan. In order to waive the County's medical plan coverage, I must provide proof of my other medical plan coverage. Further, I understand the County shall provide compensation in the manner approved by the Board of Supervisors for employees in my classification. I understand there are restrictions on when I would be allowed to re-enroll.

I understand that by signing below, I am acknowledging I have freely waived participation in the County's medical plan and I am enrolled in other medical plan coverage that meets the minimum standards under the ACA. Should changes take place affecting eligibility of this enrollment, I will immediately inform Stanislaus County Employee Benefits of the change.

Employee Signature:	Date:

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Revised 10/01/2021