CHIEF EXECUTIVE OFFICE

Human Relations Division
EMPLOYEE BENEFITS

2024 Stanislaus County Proof of Other Coverage Form

You have elected to waive your Stanislaus County medical plan coverage effective January 1, 2024, for the 2024 Plan Year. To receive the standard medical waive credit, you must be enrolled in a non-County qualified medical insurance group coverage program. The plan must meet minimum standards under the ACA and you must provide County Benefits with proof of your other medical coverage.

Please **complete,** sign, and return this form with 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 may be a letter from the employer or health carrier providing the coverage and a copy of a detailed confirmation statement, or a copy of your medical plan ID card.

Submit this completed and signed form along with the supporting documentation via e-mail to countybenefits@stancounty.com no later than 5:00 pm, Friday, November 17, 2023.

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.** **AND** ☐ **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.:

3. Complete the information below and attach documentation as described above:

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

4. 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. To waive the County's medical plan coverage, I must complete this form or 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: