Mt. San Antonio College

Medical Benefits Waiver Form

Name: _____ **Employee ID**: _____ **Date**: _____

Address: _____ **City**: _____ **State**: _____ **Zip Code**: _____

Insurance Carrier Name: _____ **Policy Number:** _____

Name of Person or Group Providing Medical Coverage: _____

Relationship: _____

Employer: _____

Please be sure to attach proof of comparable group insurance coverage to this form.

I, _____, acknowledge that I have been offered the opportunity to purchase health coverage from my employer, Mt. San Antonio Community College for myself and my dependents but do not wish to enroll at this time. I hereby certify, under penalty of perjury, that the benefits provided under the above policy are, at a minimum, comparable to the coverage provided by the Mt. San Antonio Community College District's health benefits program. I also understand that this waiver will be effective beginning with January 1st of the following premium year period. Finally, I understand that I will be required to reapply for this waiver each benefit year during open enrollment.

Note: *In the event of loss of coverage which triggers a qualifying life change, please refer to "Declaration of Coverage HBD12A".*

_____ _____

Signature Date

- For office use only -

Approved by: _____ _____

Date: