City of Pittsburg
Medical Alternative Waiver Statement

Employee Name _____ Department_____

Medical Alternative Statement

I hereby waive health insurance plan coverage through the City as I am covered as a dependent under the health insurance plan described below. In consideration of this waiver, I understand that the City shall pay me additional monies in accordance with my collective bargaining agreement. I understand that if I waive health insurance plan coverage there are restrictions on when I may later enroll into health insurance sponsored by the City. I am eligible to enroll only during Open Enrollment or if I become eligible for one of the following "Special Enrollment" reasons:

- Family Unit change due to new dependents within 30 days after marriage, birth or adoption
- Loss of other coverage within 30 days after loss
- Court or administrative order within 31 days of order
- Reemployment after military service

The City shall provide a medical/dental alternative payment to those employees eligible for medical/dental coverage and who provide verification of medical coverage. For employees declining coverage, the following medical/dental alternative payment will be paid:

Medical Single Coverage	$200/month
Medical Dual Coverage	$300/month
Medical Family Coverage	$500/month
Dental Coverage	$25/month

Medical Waiver

☐ For myself (single coverage)
☐ For myself and one dependent (dual coverage)
☐ For my family (family coverage)

Attached are copies of the health plan membership cards for myself and all covered dependents.

***Dental Waiver* - I am declining coverage because:**

☐ I have coverage through my spouse's policy
☐ Other (specify) _____

I certify that the information contained in this form is correct and understand that falsification of this form is grounds for disciplinary action.

Employee's Signature_____ Date_____

Human Resources Use Only

❑ *Verification received by*_____ *On*_____ *Amount*_____ *Effective* _____
❑ *Finance has been advised of approval*