



**ELECTION OF CASH IN-LIEU OF BENEFITS
PARTICIPATION IN THE GROUP MEDICAL AND DENTAL INSURANCE**

Return this form and attachments to PCCD Benefits Office, 333 East 8th Street; Oakland, Ca 94606 along with your verification of other group insurance coverage within 30 days of eligibility. Eligibility criteria for the cash-in-lieu (CIL) of benefits plan is based on the collective bargaining agreement covering employment with Peralta and is subject to post enrollment audit.

In general, this CIL benefit is available to active employees, including contract faculty, and benefit-eligible employees in unions PFT, Local 39; SEIU 1021, managers, confidential employees and eligible part-time and hourly faculty or short-term hourly employees.

I hereby waive enrollment into the following group insurance plans, which I am otherwise eligible for based on my own employment eligibility with Peralta Community College District.

Section A-Waiver/Election

I am waiving (initial as applicable)

____ Peralta Group Medical Plan Enrollment; I am therefore eligible for cash benefits of \$225/month

____ Peralta Group Dental Plan Enrollment; I am therefore eligible for cash benefit of \$25/month

Section B-Affirmations/Verifications:

I affirm that my tax dependents and/or I, are covered by another medical and/or dental plan that is not individual market coverage, and am attaching dated verification of my current coverage offered through:

(Name of Medical Carrier/Plan Administrator)

(Name of Dental Carrier/Plan Administrator)

Initial

____ I understand that the verification must include group identification number, effective date of coverage information for each. I understand that Peralta Community College District reserves the right to verify this coverage.

Check one:

____ I have tax dependents (I am attaching coverage verification for all tax dependents)

____ I do not have dependents

Section C-Cash Options/ Acknowledgements:

Based on the waiver options indicated above, I am eligible for cash in the amount of:

____ \$225 to be received on a monthly basis as a taxable benefit in-lieu of individual participation in a Peralta Community College District group medical plans.

____ \$25 to be received on a monthly basis as a taxable benefit in-lieu of individual participation in a Peralta Community College District group dental plan (*not currently available to part-time and hourly faculty or short-term hourly employees.*)

Section D-Other Considerations & Disclosures:

My signature below affirms my understanding of, and compliance with, the statements below:

1. I cannot opt for cash if my only other medical insurance is stand alone Medicare, TriCare, Medi-Cal, COBRA or an individual plan.
2. Under no circumstances will the cash benefit be made retroactive beyond 30 days.
3. Participation in the cash-in-lieu of benefits plan is voluntary.
4. If I wish to enroll in any of Peralta Community College District's group medical or dental plans at a later date, I will be subject to that plan's enrollment rules and benefit plan design in effect at that time.
5. It is my responsibility to complete the Peralta Benefits Enrollment form and submit documentation within 30 days of loss of coverage under another group plan to re-enroll in a Peralta benefit plan at a future date as required by the Health Insurance Portability and Accountability Act (HIPPA) of 1996. Other events which permit me to rescind this waiver are noted below:
Marriage, Divorce, Legal Separation, Birth, Adoption, Death, Termination of employment (unit member or eligible dependents); exhaustion of COBRA, individual no longer resides or works in HMO service area, individual ceases to be a dependent, plan terminates a benefit plan option, involuntary loss of coverage under another group plan, Children's Health Insurance Plan/ Medicaid (Medi-Cal) Rule; meeting or exceeding a plans lifetime maximum on all benefits.

Name (please print)

Signature

Date

Social Security Number

Date of Birth

Peralta Employee ID

Benefit Program PFF/PTC/PRB / Date of Benefits Office Approval _____ Payroll Effective _____