

COUNTY OF SANTA BARBARA

**WAIVER OF MEDICAL/DENTAL COVERAGE
FOR PERMANENT EMPLOYEES**

I, _____, SSN: _____,
declare as follows:

- 1) I am a permanent part or full-time employee of the County of Santa Barbara.
- 2) I understand that I am entitled to have the County pay its normal contribution provided I pay the balance of such required premium, if any.
- 3) I realize that should I waive coverage now and later decide to enroll in one of the County Health and Dental Insurance Programs, **I WILL NOT HAVE THE OPPORTUNITY TO DO SO UNTIL THE NEXT ANNUAL OPEN ENROLLMENT PERIOD OR UNLESS I MOVE FROM PART-TIME TO A FULL-TIME POSITION. If I decline coverage during a leave of absence, I understand that I am eligible for continued health insurance (COBRA) while on leave and I acknowledge that I have been notified of these rights and am waiving my rights to such coverage.**
- 4) Effective _____ * I do not (or no longer) wish to be covered under one of the County's Health and Dental Insurance Programs; and I hereby request and instruct the County not to make, and I hereby relinquish and waive my right to have the County make, any (further) insurance premium payments for or on my behalf. In addition, I advise the County that I will not make any (further) payments of my share of such insurance premiums.
- 5) I hereby agree to indemnify and hold harmless the County, its officers and employees, from and against any claim, liability, cost and expense of whatever nature which may arise from or as a result of the non-payment by the County of the insurance premium pursuant to the foregoing instructions.

Signature

Department Name

Date

***THIS DATE MUST BE THE FIRST DAY OF A MONTH.**