Colton-Redlands-Yucaipa-ROP

MEDICAL COVERAGE WAIVER FORM FOR 2017-2018

Name: ____
(Please Print)

Social Security Number: ___________________________________

I have had the medical benefits program for the employees of Colton-Redlands-Yucaipa Regional Occupational Program presented to me for my participation and I have elected to decline coverage for the following reason:

☐ Covered by spouse's insurance program.

☐ Covered under another employer plan.

☐ Covered by Medicare Supplement.

☐ Covered by retiree plan from former employer.

I understand that by declining coverage at this time, I will not be eligible to elect medical coverage until the next open enrollment or if a qualifying event occurs. I further understand that I will become eligible within 30 days of the event.

I will supply CRY-ROP Human Resources Department with proof of valid Medical Insurance for all dependents.

____________________ ____________________________________
Date Signature