



SUBMIT FORM TO Risk Management Office:
701 N. Madison Street
Stockton, CA 95202
(209) 933-7110

Declaration of Health Coverage: HBD-12A Form

EMPLOYEE INFORMATION: PRINT ALL REQUIRED INFORMATION

Social Security Number	Name (First)	Middle	Last
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ELECTION

- I **elect** to enroll myself only.
- I **elect** to enroll myself and all eligible dependents.
- I **elect** to enroll myself. My eligible have other health insurance coverage.

DECLINE

- I **decline/opt** out enrollment for myself and my eligible dependents because we have other health insurance coverage (**evidence of other coverage is required**)
- I **decline/opt** out enrollment for myself and or my eligible family members for reasons other than having health insurance coverage

SUSD as a Plan Sponsor is required under Health Care Reform to offer Medical Health Coverage to ALL Employees who work 20 hours per week or more.

By signing the Medical Declaration of Health Coverage Form, I am stating that I agree and understand the conditions of this agreement.

If you or your dependents lose health insurance coverage, you can enroll in the CalPERS Health Benefits program. You must request enrollment within 60 days from the date you lose coverage.

If you do not request enrollment within 60 days, you or your dependents must wait until 90 days from date of request or the next Open Enrollment period before you can enroll in the program. Your effective date of coverage will be the month following the 90-day waiting period or the Open Enrollment effective date.

Employee Signature

Date

Risk Management Staff Signature

Date