Stockton Unified School District
Since 1852

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

Effective Date _____
Staff Initials _____
Bargaining Unit _____

MEDICAL COVERAGE WAIVER AND MEDICAL REBATE

MY SIGNATURE BELOW HEREBY CONSTITUTES AND SERVES AS NOTIFICATION TO STOCKTON UNIFIED SCHOOL DISTRICT THAT I AM WAIVING THE MEDICAL AND CHIRO INSURANCE COVERAGE BY SUSD WHICH WAS PRESENTED TO ME ON DATE: _____/_____/_____

FURTHERMORE, I AGREE AND UNDERSTAND THAT I AM SOLELY RESPONSIBLE FOR SECURING MEDICAL COVERAGE FROM ANOTHER PROVIDER OTHER THAN SUSD, AND I AGREE TO HOLD HARMLESS SUSD FOR ANY PERSONAL LOSSES INCURRED THAT WOULD HAVE COVERED UNDER THE DISTRICTS MEDICAL PLANS.

ELIGIBILITY FOR THE MEDICAL REBATE PROGRAM "REQUIRES" ONE OF THE FOLLOWING DOCUMENTS:

1. Evidence of other Coverage Documentation (Insurance Card)

2. Written statement from significant other, parent or guardian's Employer verifying coverage (must be on letterhead) (District Employees will need to provide option #1)

   FAILURE TO NOTIFY THE DISTRICT OF YOUR LOSS OF COVERAGE WILL RESULT IN THE REPAYMENT OF ALL MEDICAL REBATE PROCEEDS RECEIVED FROM THE DATE OF THE LOSS OF COVERAGE.

   I agree and understand that by not providing one of the above documents to the Benefits Office at time of enrollment that I will not be eligible for the Medical Rebate program until documentation is provided and approved.

_____ _____
Employee Name *(Please Print)* Employee ID#

_____
Social Security Number

_____ _____
Employee Signature **Date**