



Internal Services Agency

Department of Personnel Services

Employee Benefits Office

AnnMarie Meyer, Manager

Terry Schutten, County Executive

Mark Norris, Agency Administrator

David Devine, Department Director

County of Sacramento

RETIREE WAIVER OF COVERAGE

Retiree Name _____ SSN _____

Address _____

City _____ State _____ Zip Code _____

I am waiving my Medical Coverage Reason _____

I am waiving my Dental Coverage Reason _____

My signature below authorizes the Employee Benefits Office to terminate my County sponsored medical/dental coverage. By submitting this cancellation notice, I am aware that this cancels any health/dental insurance subsidy that I am currently eligible to receive from the Sacramento County Employees Retirement System.

I understand that according to the Retiree Health Insurance Program Administrative Policy, an Annuitant may enroll in the County sponsored health coverage within thirty (30) days of a Qualified Status Change Event, or during any enrollment period specified in the sole discretion of the County. Such enrollment shall be contingent upon the Annuitant presenting proof that is satisfactory to the County that the Annuitant has been continuously covered by another group insurance plan or individual Medicare Advantage plan for a period of not less than 12 months with no break in coverage exceeding 63 calendar days immediately prior to the requested enrollment in a County sponsored plan.

Retiree Signature

Date

Office Use Only

Reviewed By	Date	Effective Date of Waiver