City of Huntington Beach

Request to Opt Out of Health Insurance Coverage

Name: ________________________________ Association: ____________

Social Security Number: __________________

Check one:

☐ I decline health insurance coverage enrollment for myself

☐ Medical ☐ Dental ☐ Vision

☐ I decline health insurance coverage enrollment for myself and my eligible dependents

☐ Medical ☐ Dental ☐ Vision

Initial This is to attest that the City of Huntington Beach has offered to me enrollment in the City sponsored medical/dental/vision insurance plans for myself and/or my eligible dependents.

Initial I certify that I am currently enrolled in another **EMPLOYER SPONSORED GROUP** medical plan (Affordable Care Act Group Health Plan Mandate)

Medical Plan: ____

Coverage Effective Date: ____________________________________

Name of Employer: ____

Initial Proof of group health coverage attached*

Initial I understand I am required to annually re-certify my medical opt out eligibility

Employee Signature: ____

Date Signed: ____

**In order to opt out of the City of Huntington Beach's medical plan, proof of group health coverage must be provided. If proof of group health coverage is not attached to this form, you will not be able to opt out for the 2017 plan year and must elect to enroll in a City of Huntington Beach's sponsored medical plan.*