LOS ANGELES COUNTY
SANITATION DISTRICTS
Converting Waste Into Resources

1955 Workman Mill Road, Whittier, CA 90601
Mailing Address: P.O. Box 4998, Whittier, CA 90607-4998
Telephone (562) 908-4288
Human Resources Fax (562) 692-3056

Medical Opt-Out Attestation Form

Monthly employees may receive cash in lieu of enrolling in the Districts' offered medical coverage if they provide proof of minimum essential coverage ("MEC") for themselves and their tax family (if applicable) through another source (other than coverage in the individual market, whether or not obtained through Covered California). The cash-in-lieu amount varies depending on bargaining unit. Employees in the **Blue Collar, Confidential, Professional, Professional Supervisory, Supervisory and Management** bargaining units may receive $360 per month. Employees in the **Energy Recovery, Technical Support and White Collar** bargaining units are eligible to receive $287 per month.

The Districts will not make cash-in-lieu payments if the Districts knows or has reason to know that the employee or a member of the employee's tax family does not have the alternative coverage. The monthly payments begin in January of the calendar year subsequent to opting-out. The payments are treated as taxable income for the tax year in which payments are received. Also, these payments are not considered compensation for retirement purposes. Employees who are not in a paid status, or a status which would qualify for a Districts' contribution to medical coverage, are not eligible for cash-in-lieu payments.

If you opt-out and lose coverage through the other source during the course of the plan year, you may be eligible to enroll in a Districts' offered medical plan. This is not guaranteed and is subject to plan restrictions. If you become a member of the Districts' medical plans, the opt-out payments will stop.

To request to opt-out, please complete the information below and send to Human Resources-Employee Benefits. You must include proof of other coverage (generally a copy of the front and back of your insurance card and/or an enrollment letter that identifies the medical enrollment date) and sign the attestation on the next page. If your name is not on the insurance card, you will need to contact the insurance company to get a letter for verification of coverage and the letter will need to include your name and effective date of the plan. You must also complete CalPERS form HBD-12 (Declaration of Health Coverage).

EMPLOYEE INFORMATION		
Name	SSN	Employee #
Daytime Phone Number	Bargaining Unit	

SUPPORTING DOCUMENTATION
Other group medical plan information must be provided as indicated below:
Name of covered employee _____
Name of alternate medical plan _____
Effective date of medical plan _____

Medical Opt-Out Attestation Form

ATTESTATION:

I certify that the County Sanitation Districts of Los Angeles County has offered myself and my dependents minimum essential coverage and I decline to enroll in the offered medical coverage. I certify that I have or will have alternative minimum essential coverage (other than coverage in the individual market, whether or not obtained through Covered California) for the next calendar year and I have attached proof of other coverage. I certify that all of my dependents for whom I expect to claim a personal exemption deduction during the next calendar year (tax family) have or will have minimum essential coverage (other than coverage in the individual market, whether or not obtained through Covered California) for the next calendar year.

I understand that if I waive coverage at this time, I must wait until the next Open Enrollment period to re-enroll unless I meet the criteria under CalPERS "Special Enrollment – Loss of Coverage." Additional information on special enrollment due to loss of coverage is available in the CalPERS Health Program Guide, available on the Human Resources-Employee Benefits intranet page, or may be requested from the Human Resources-Employee Benefits staff.

I understand this opt-out election is for only one plan year, and that I must submit the Medical Opt-Out Attestation form again during the next Open Enrollment period to continue to opt-out.

I understand that if I lose coverage I must notify Human Resources-Employee Benefits within 60 days from the date coverage is lost.

Employee's Signature: _____ Date: _____

FOR HUMAN RESOURCES DEPARTMENT USE ONLY

	Date	Initials	Date Received / Notes
Unit Confirmed			Notes:
Documentation Verified			
Entered/Processed - OAB			
Entered/Processed - CP			

Health Account Management Division
P.O. BOX 942715
Sacramento, CA 94229-2715
888 CalPERS (or **888**-225-7377) | TTY (877) 249-7442
FAX (800) 959-6545
www.calpers.ca.gov

Health Benefits Plan Enrollment for Active Employees (HBD-12)

SECTION A: Applicant Information

1. Employee Name: *(First)* *(M.I.)* *(Last)*

2. Hire Date: (mm/dd/yyyy)

3. CalPERS ID or Social Security Number:

4. Date of Birth: *(mm/dd/yyyy)*

5. Gender: ☐ Male ☐ Female ☐ Nonbinary

6. Physical Address: *(Street)* *(City)* *(State)* *(ZIP)* *(County)*

7. Mailing Address (If different): *(Street)* *(City)* *(State)* *(ZIP)* *(County)*

8. Use Work ZIP Code for Health Eligibility: ☐ Yes ☐ No *If yes, enter zip code here: (ZIP)*

9. E-mail Address:

10. Primary Phone: **Alternate:**

SECTION B: Type of Action

11. ☐ Enroll in a Health Plan ☐ Add/Delete Dependents ☐ Change Health Plan ☐ Cancel All Coverage ☐ Decline Coverage

SECTION C: Type of Permitting Event

12. ☐ New Employee ☐ New Contracting Agency ☐ Marriage or Domestic Partnership Date *(mm/dd/yyyy)*: ☐ Open Enrollment ☐ Move
☐ Delete Dependent Due to Death ☐ Divorce or Domestic Partnership Termination ☐ Birth/ Adoption ☐ Other:

13. Permitting Event Date: (mm/dd/yyyy)

14. Name of Health Plan: (If changing health plans, list new plan name)

SECTION D: Subscriber and Dependent Information (List yourself and all of your dependents)

15. Name (First, M.I., Last)	Relationship Code *1	Gender	Date of Birth (mm/dd/yyyy)	CalPERS ID or Social Security Number	Action	Primary Care Physician
	SELF	☐ M ☐ F ☐ Nonbinary			☐ Add ☐ Delete	
		☐ M ☐ F ☐ Nonbinary			☐ Add ☐ Delete	
		☐ M ☐ F ☐ Nonbinary			☐ Add ☐ Delete	
		☐ M ☐ F ☐ Nonbinary			☐ Add ☐ Delete	
		☐ M ☐ F ☐ Nonbinary			☐ Add ☐ Delete	
		☐ M ☐ F ☐ Nonbinary			☐ Add ☐ Delete	

*1 **Relationship Codes:** **S** - Spouse **DP** - Domestic Partner **NC** - Natural Child **SC** - Step Child **AC** - Adopted Child **DPC** - Domestic Partner Child **PCR** - Parent Child Relationship

SECTION E: Enrollment

16. To enroll, carefully review the information in this section and check the box:

☐ **I ELECT TO ENROLL** in (or **MAKE CHANGES TO**) a health benefits plan as indicated above and agree to authorize deductions from (1) my salary to cover my share of the cost of enrollment as it is now or as it may be in the future (2) my retirement allowance to continue health benefits coverage into retirement. **I CERTIFY** that the information provided herein is accurate and listed dependents are eligible family members as defined in the Public Employees' Medical and Hospital Care Act.

I VOLUNTARILY enroll into the selected Health Plan. **I AGREE** to read the associated Evidence of Coverage (EOC) and any subsequent EOCs in the following years to understand the benefits of the plan. The Subscriber and all eligible dependents agree to all the terms and conditions of the EOC and the Health Plan.

I UNDERSTAND that enrolling in certain health plans requires binding arbitration and that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California Law and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. The parties to this agreement, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury and instead are accepting the use of arbitration.

17. To decline, carefully review the information in this section and check the box:

☐ **I DECLINE ENROLLMENT** into the CalPERS Health Program for myself and my dependents.

I UNDERSTAND that if I choose to enroll at a later date, I must wait at least 90 days after I request enrollment or until the next Open Enrollment (OE) period before enrolling in the CalPERS Health Program. Furthermore, if I or my dependents involuntarily lose other health insurance coverage, I may request enrollment into the Program within 60 days from the date of lost coverage. If I do not request enrollment within 60 days, I must wait at least 90 days or until the next OE period before I can enroll. The effective date of coverage will be the first of the month following the 90 day waiting period or the OE effective date.

18. Employee Signature:

19. Date: *(mm/dd/yyyy)*

SECTION F: CalPERS Privacy Notice

The privacy of personal information is of the utmost importance to CalPERS. The following information is provided to you in compliance with the Information Practices Act of 1977 and the Federal Privacy Act of 1974.

Information Purpose
The information requested is collected pursuant to the Government Code Sections (20000 et seq.) and will be used for administration of Board duties under the Retirement Law, the Social Security Act, and the Public Employees' Medical and Hospital Care Act, as the case may be. Submission of the requested information is mandatory. Failure to comply may result in the system being unable to perform its functions regarding your status.

Please do not include information that is not requested.

SSN
Social Security numbers are collected on a mandatory and voluntary basis. If this is CalPERS first request for disclosure of your SSN, then disclosure is mandatory. If your SSN has already been provided, disclosure is voluntary. Due to the use of Social Security numbers by other agencies for identification purposes, we may be unable to verify eligibility for benefits without the number.

Social Security numbers are used for the following purposes:

1. Enrollee identification
2. Payroll deduction / state contributions
3. Billing of contracting agencies for employee / employer contributions
4. Reports to the CalPERS system and other state agencies
5. Coordination of benefits among carriers
6. Resolve member appeals, complaints, or grievances with health plan carriers

Information Disclosure
Portions of this information may be transferred to other state agencies (such as your employer), physicians, and insurance carriers, but only in strict accordance with current statutes regarding confidentiality.

Your Rights
You have the right to review your membership files maintained by the system. For questions about this notice, our Privacy Policy, or your rights, please write the CalPERS Privacy Officer at 400 Q Street, Sacramento, CA 95811 or call our Customer Contact Center at 888-CalPERS (888-225-7377).

SECTION G: Privacy Information

Submission of the requested information is mandatory. The information requested is collected pursuant to the California Government Code (sections 20000 et seq.) and is used for administration of the CalPERS Board's duties under the Public Employees' Retirement Law, the Social Security Act, and the Public Employees' Medical and Hospital Care Act, as the case may be. Portions of this information may be transferred to other governmental agencies (such as your employer), physicians and insurance carriers but only in strict compliance with current statutes regarding confidentiality. Failure to supply the information may result in CalPERS being unable to perform its functions regarding your status.

You have the right to review your CalPERS membership files. For questions concerning your rights under the Information Practices Act of 1977, please contact the CalPERS Customer Contact Center at **1-888-CalPERS** (or 1-888-225-7377).

Section 7(b) of the Privacy Act of 1974 (Public Law 93-579) requires that any federal, State, or local governmental agency requesting an individual to disclose a Social Security account number to inform the individual whether that disclosure is mandatory or voluntary, by which statutory or other authority such number is solicited, and what uses will be made of it. Section 111 of Public Law 101-173 requires group health plans to collect and provide member Social Security numbers for the coordination of federal and State benefits. Furthermore, the CalPERS health program requires each enrollee's Social Security number for identification purposes and to verify eligibility for benefits.

The CalPERS health program uses Social Security numbers for the following purposes:

1. Enrollee identification for eligibility processing and eligibility verification
2. Payroll deduction and State contribution for State employees.
3. Billing of contracting agencies for employee and employer contributions.
4. Reports to CalPERS and other state agencies.
5. Coordination of benefits among health plans.
6. Resolution of member complaints, grievances and appeals with health plans.

IMPORTANT: It is your responsibility to notify your personnel office when there are any changes in your family situation. Changes include domestic partnership termination, establishment of a parent-child relationship, acquisition of a dependent child, change of address, marriage, divorce, legal separation, and death. Failure to notify your personnel office may result in adverse consequences.

SECTION H: For Employer Use

Please retain original signed form and all supporting documentation or affidavits in employee file. DO NOT send to CalPERS.

20. **Agency Name:**	21. **Date of Hire**: *(mm/dd/yyyy)*	22. **Retirement System**: ☐ CalPERS ☐ CalSTRS ☐ Other
23. **CalPERS Employer ID:**	24. **Division ID:**	25. **Employee Bargaining Unit/Employee Group:**
26. **Payroll Office:** ☐ State Controller's Office ☐ Non Central ☐ Public Agency Billing	27. **Date Received by Employer:**	28 **Effective Date:** *(mm/dd/yyyy)*

I hereby certify under the penalty of perjury that I am a duly appointed, qualified and acting Health Benefits Officer (HBO) of the above named agency, and the payment by the agency as provided by Section 22870-22905 of the Government Code is hereby approved. Final determination of eligibility for the enrollment action specified will be made by the Board of Administration, Public Employees' Retirement System, in accordance with the Public Employees' Medical and Hospital Care Act and the regulations implementing the Act.

29. **Health Benefits Officer:** (Print name)	30. **Signature:**	31. **Date:** *(mm/dd/yyyy)*	32. **Phone Number:**

33. **Remarks:**

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Please do not include information that is not requested.

Social Security Numbers

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Social Security numbers are used for the following purposes:

1. Enrollee identification
2. Payroll deduction/state contributions
3. Billing of contracting agencies for employee/employer contributions
4. Reports to CalPERS and other state agencies
5. Coordination of benefits among carriers
6. Resolving member appeals, complaints, or grievances with health plan carriers

Information Disclosure

Portions of this information may be transferred to other state agencies (such as your employer), physicians, and insurance carriers, but only in strict accordance with current statutes regarding confidentiality.

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