Full-Time Employee
Opt-Out/Waiver of Insurance Coverage

To be eligible to opt out of the medical, dental, and/or vision coverage offered to you by the City of Tacoma, you must sign this "Waiver of Insurance Coverage" form and provide written proof of alternative medical, dental, and/or vision insurance coverage. These documents must be returned to the Human Resources Department Benefits Office within 30 days of your date of hire or qualifying life event. It is recommended that you keep a copy for your personal records.

If you choose to waive one or more of these benefit plans, you will not be able to apply for the waived coverage until the next annual Open Enrollment period, or sooner if you experience a qualifying life event. Examples of a qualifying life event include, but are not limited to:

- Marriage, establishment of a domestic partnership, termination of domestic partnership, divorce or legal separation
- Gaining a dependent by birth, adoption/placement of adoption for a child, addition of a stepchild or obtaining legal guardianship of a child
- Losing a spouse, domestic partner or dependent through death
- Loss of other coverage

Waiver Agreement: *(Each box must be checked)*

☐ I understand that I have the right to decline the medical, dental, and/or vision insurance coverage offered to me by the City of Tacoma because I have alternative medical, dental, and/or vision insurance coverage.

☐ I understand if I waive the medical, dental, or vision insurance coverage, I am required to notify the Human Resources Benefits Office within 30 days if I lose my alternative medical, dental, and/or vision insurance coverage or I will be unable to enroll for coverage until the next Open Enrollment period or sooner if I experience a qualifying life event. In which case, I must contact the Human Resources Benefits office to enroll for coverage within 30 days of the qualifying life event.

☐ I hereby waive the following coverage offered to me by the City of Tacoma (please check all that apply):

☐ **Medical** ☐ **Dental** ☐ **Vision**

☐ **Attached is my written proof of alternative medical, dental, and/or vision coverage.**

Name: _____ **Employee No:** _____
(Please print)

Signature: _____ **Date:** _____

City of Tacoma Benefits Office | 253-573-2345 | benefits@cityoftacoma.org | 747 Market Street, Room 1420, Tacoma, WA 98402