San Diego Unified
SCHOOL DISTRICT

FINANCE DIVISION
Employee Benefits Department
P - 619.725.8130
F - 619.725.8132

REQUEST FOR CERTIFICATE OF HEALTH COVERAGE

Employee Name _____ Employee ID #_____

My spouse's employer requires written verification of their coverage as my dependent under the San Diego Unified School District's group health plan. Please **mark only one box** below and provide your signature under the statement selected:

☐ My spouse **does not receive** a cash benefit to waive medical coverage under their employer's plan:

_____ _____
Signature of Employee Date

☐ My spouse **does receive** a cash benefit to waive medical coverage under their employer's plan:

Authorization: I understand that in the event my spouse waives medical coverage through another employer, in exchange for a cash payment, terms in the bargaining unit contract (excludes AASD represented and unrepresented positions) require the district to deduct $100/month from each of the (10) monthly paychecks issued to me from September to June. This is an after-tax deduction and will remain in force for as long as my spouse continues to receive cash in lieu of benefits from their employer.

_____ _____
Signature of Employee Date

Please let us know how we should deliver the Certificate of Coverage:

☐ Email _____
☐ Call for Pickup _____
☐ Mail _____
☐ Fax _____

Return the completed request to the Employee Benefits Department. Please allow up to 7 business days for processing.

Employee Benefits Department
4100 Normal St Room 1150
San Diego, CA 92103
Ph: (619) 725-8130 Fax: (619) 725-8132
Email: employeebenefits@sandi.net