STATEMENT OF NON-PARTICIPATION
SAN DIEGO UNIFIED SCHOOL DISTRICT
GROUP HEALTH BENEFITS

Employee ID#	Name: Last First Middle Initial	Birth Date	Location Number	Name of Work Location	Effective Date
Home Address	City State	Zip	Home Phone	Certificated ☐	Classified ☐

☐ Group Medical Benefits Coverage

☐ Group Dental Benefits Coverage

☐ Group Vision Benefits Coverage

I do not wish to participate in the District-sponsored group health benefits plan(s) indicated above. I understand that the premium dollars, which would have been contributed by the District for my coverage, will not be added to my salary. I also understand that unless I qualify under the loss of other coverage provision of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) I will not have the opportunity to enroll for coverage until a subsequent open enrollment period.

Note: Under a federal law known as HIPAA, when an employee or a dependent does not enroll for medical coverage because he/she has other coverage, a special enrollment provision allows an employee/dependent to enroll at times other than open enrollment when loss of the other coverage occurs. Appropriate enrollment application must be made within 31 days following the loss of other coverage. If you are declining coverage through the San Diego Unified School District because you have other coverage, please check here. ☐

Employees are urged to give serious consideration to the consequences of declining coverage.

Employee Signature _____ Date _____