Declination of Healthcare Coverage Affidavit

I hereby certify that:

1. I have been given an opportunity to fully participate in the group medical plans provided through Miami-Dade County Public Schools (M-DCPS).
2. The benefits of the plans have been thoroughly explained to me, and I decline to participate.
3. I have other medical coverage currently in effect (not a School Board-sponsored plan).
4. I understand that if I desire to apply for medical insurance at a later date, I may enroll only during an annual enrollment period determined by M-DCPS or during a "special enrollment period" (Change in Status) following an IRS acceptable change in status event. For example, you may in the future be able to enroll yourself or your dependents in a group medical plan through the School Board if you or your dependents lose coverage under an existing employer provided medical plan, provided that you request enrollment within 30 days after your other group product coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption (or placement for adoption), you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the event. In case of COBRA continuation coverage, you may be eligible for a special enrollment period if the COBRA coverage is exhausted. A special enrollment period is not available if coverage under your prior plan or COBRA coverage was terminated for cause or as a result of failure to pay any contributions toward the cost of coverage on a timely basis. **NOTE:** Internal Revenue Service (IRS) guidelines state that the loss of insurance through an **individual** Healthcare **plan does not** constitute a valid Change in Status event.
5. I understand that I will not be enrolled in a Board-Paid medical plan. I will receive Board-Paid Standard Short-Term Disability and will receive $100 per month paid through the payroll system. (This may be subject to withholdings and FICA.)
6. I understand that I must provide proof of other group healthcare coverage. Otherwise, I understand that I will be auto-assigned CIGNA OAP 20 (employee only) coverage.

I have read, understand and agree to comply with the requirements stated above.

_____ _____

Print Name Employee Number

_____ _____

Signature Date

Attached is my proof of group healthcare coverage.

NOTE: Please fax this affidavit and proof of other group healthcare coverage to 305-995-1425.