OAKLEY
CALIFORNIA

Effective Date_____

Date of Hire_____

Certified by_____

Human Resources Use Only

Participation Agreement & Disclosure Statement

Name: _____ Department/Division: _____

Employee #: _____ Classification: ❍Full –Time ❍Part – Time: _____%FTE

Complete to Elect Cash-Back

Please answer each question below.

Are you covered under another group health insurance plan? ❍Yes ❍No*

If so, which type of plan?

- ❍ Spouse, Domestic Partner or Parent's employer's plan
- ❍ Medi-Cal
- ❍ Tri-Care

I am fully aware of the following terms and conditions under which this option operates and to which I am subject in agreeing to participate in the option. The terms and conditions are outlined below.

- I have attached Proof of Alternate Coverage.
- The Cash-back payments will be distributed to me on a bi-weekly basis and that these payments are reported as taxable income that will be reflected in withholding contributions on my paycheck.
- The monthly medical payments made to me will be the equivalent of the Council Approved contribution or pro-rated amount based on the percentage of full-time equivalency.
- The choice to withdraw or renew my membership in the Option may only be made during the City's Annual Open Enrollment period. Exception to this rule may only be made under circumstances in which my alternative coverage is terminated and proof is provided to Human Resources.
- Current employees choosing to elect this option during the City's Annual Open Enrollment: Insurance coverage under the plan will no longer be in effect beyond the effective date of this option; 12:01 am on December 1 of the year of the same year.
- The agreed upon Terms and conditions will remain in effect for one year from the effective date of this agreement. I further certify that the information furnished is true and correct.

*Note. If you do not have health insurance, are covered under an individual plan or through Covered California, you are not eligible to receive Cash-Back.

*I certify that the City of Oakley has offered me and my dependents health coverage. I certify that I (and any applicable dependents) currently have medical insurance coverage through my spouse/domestic partner/parent's employer. I further certify that I intend to maintain coverage on my spouse/domestic partner/parent's employer's health plan on an on- going basis. I agree to notify the Department of Human Resources within 30 days (60 days for Medi-Cal eligibility) should I lose coverage or **change** my coverage under this medical insurance program. I understand that in order to meet the requirements to receive cash-back I am required to answer truthfully and provide proof of other health insurance coverage. Failure to provide proof of coverage will result in denial of Cash Back.*

_____ _____

Employee's Signature Date

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Complete to Cancel Cash-Back

I am cancelling Cash-Back for the following reason:

- ❍ I am now enrolling in the City sponsored plan
- ❍ I am no longer covered under another qualified group health plan

I have submitted proof of loss of coverage ❍Yes ❍No

_____ _____

Employee's Signature Date