City of Oakley Cash-Back
Employee Election Form

Effective Date_____

Date of Hire_____

Certified by_____

Human Resources Use Only

_____ _____

Employee Name Employee #

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
- ❍ Retirement Group Coverage

*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

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

_____ _____

Employee's Signature Date

Cash-Back will be effective the first of the month following the receipt of Application and evidence of coverage to the Department of Human Resources. Incomplete forms will be returned. Cancellation will be effective the first of the month following loss of coverage.

Updated October 2016