Medical Opt-Out Cash Back Attestation Form

a. I understand that I have been offered the opportunity to enroll myself and my eligible dependents in LAUSD sponsored medical plan(s) and that the medical plan(s) are considered to be minimum essential coverage (MEC) in accordance with the Affordable Care Act (Health Reform).

b. I understand that without medical plan coverage I (and my dependents, if any) could have a financial penalty applied when my/our personal income taxes are filed with the Internal Revenue Service (IRS). I understand I can learn more about the financial penalty, called the Individual Mandate penalty, at this government website: https://www.healthcare.gov/fees-exemptions/fee-for-not-being-covered/.

c. I understand that without an IRS-approved mid-year life change event (a Special Enrollment event), **if I decline coverage now**, I will not be permitted the opportunity to enroll myself or my eligible dependents in my employer's medical plan option(s) again until my employer's next annual open enrollment time (if I am benefits-eligible at that time).

d. I understand that there is additional compensation of $250 per month provided to me if I decline coverage. I understand that **I am only able to receive this additional compensation for declining coverage if I, and all members of my expected tax family (tax family refers to dependents on the employee's tax return), have or will have for the 2019 calendar year other minimum essential coverage through** another employer's group medical plan, Medicare, Medicaid, Tricare, VA or Indian Health Services (IHS) medical plan coverage.

- I also understand that I am not eligible to receive this compensation if I or any member of my expected tax family is enrolled in individual market coverage, whether obtained through Covered California, another Marketplace established under Health Reform, or outside of the Marketplaces established under Health Reform.
- I also understand that LAUSD will not make any payment to me if LAUSD knows or has reason to know that I or any member of my expected tax family (tax family refers to dependents on the employee's tax return), does not have or will not have the required alternative coverage.
- I agree to notify LAUSD promptly if I or any member of my expected tax family (tax family refers to dependents on the employee's tax return), loses this alternative coverage, and I understand that compensation payments will be stopped at that time.
- I also understand that I will be required to attest to this alternative coverage each plan year that I decline coverage under LAUSD's group medical plan.

My signature below means that I have read and understand the above statements.

Print Name: ____ Employee #: __________________

Signed: ____ Date: ________________, 20____

Please keep a copy of this form for your records and return this form via mail, fax, or email to Benefits Administration.

Visit http://benefits.lausd.net for benefit information and forms
Risk Management and Insurance Services, Benefits Administration
P.O. Box 513307, Los Angeles, CA 90051-1307 | Tel: (213) 241-4262 | Fax: (213) 241-4247
Email: benefits@lausd.net

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