

BRENTWOOD UNION SCHOOL DISTRICT**2027 WAIVER OF GROUP MEDICAL COVERAGE FORM**

Please sign, date and return this form along with the required documentation no later than **October 23, 2026**, or within 30 days of initial benefits eligibility.

EMPLOYEE NAME (Please print or type legibly) Minnie Mouse	SITE/DEPARTMENT Brentwood El	PHONE # 925-555-1111
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As required by the Patient Protection and Affordable Care Act (ACA), you are being given the opportunity to enroll in medical health coverage offered by the Brentwood Union School District (BUSD). You have the right to decline, or waive coverage. If you waive coverage for you and/or your dependents under the Brentwood Union School District medical health plan, you are required to show that you have medical health coverage through another source by providing proof of coverage or by having the certificate below completed by the employer providing the alternate health coverage.

In order to receive "Cash Option" as outlined in BUSD employee association on agreements, you must provide proof of group medical coverage. Group medical coverage includes other employer-sponsored plans, Tricare Medicare and Medi-Cal. Generally, insurance purchased through insurance brokers and Covered California are **NOT** group medical coverage and exclude you from receiving "Cash Option." **As of 1/1/2024**, new hires are no longer eligible for the "Cash Option" benefit.

The following may apply if you decide to waive coverage:

- If you waive this coverage and do not obtain coverage on your own, you could be subject to a penalty under the individual responsibility requirement of the ACA and will not qualify for government subsidies to purchase individual health insurance on the Marketplace.
- If you waive coverage, you will only be allowed to enroll in the Brentwood Union School District medical health plan if you have a qualifying event (e.g. marriage, divorce, birth/adoption, loss of coverage, or change in job status). **You must request to enroll in the plan within 30 days of the qualifying event.**

I have read the above and understand the consequences of my waiver of coverage. I attest that I was offered and am eligible to enroll in a health plan that is affordable, minimum value, as defined under the ACA, through Brentwood Union School District for the period from **January 1, 2027 to December 31, 2027**, and I have decided to waive the medical coverage on an annual basis. **In the event that I lose my alternative health coverage at any time throughout the calendar year, I agree that I will immediately notify BUSD Benefits Specialist to enroll in a district provided health plan.**


Employee's Signature

10/5/2026
Date

*Non-individual market health coverage includes other employer-sponsored plans, Tricare, Medicare and Medi-Cal.

Certification of Other Coverage

(To be completed by employer providing alternate health coverage only)

This is to certify that _____ is currently insured by
Name of Employee Listed Above

_____ in the following manner:
Medical Insurance Plan Name

Name of Insured

Relationship

Effective Date of Coverage

Signature of Benefit Office

Date of Signature

Phone Number

Title

Agency/Company Name

Date BUSD Benefits Specialist Received: _____ **BUSD Benefits Specialist Signature:** _____