CITY AND COUNTY OF SAN FRANCISCO

GENERAL SERVICES AGENCY
OFFICE OF LABOR STANDARDS ENFORCEMENT
PATRICK MULLIGAN, DIRECTOR

# HEALTHY AIRPORT ORDINANCE (HAO)
# FOR EMPLOYEES IN THE QUALITY STANDARDS PROGRAM (QSP)

## VOLUNTARY WAIVER FORM

**(Operative: February 26, 2026 – December 31, 2026)**

**Attention Employees:** Please read this entire document. This waiver impacts your rights to certain health benefits provided by your employer. You are entitled to the option the employer has elected to satisfy its obligations under the Healthy Airport Ordinance. By signing this form, you may impact your rights. It is illegal for your employer to pressure, intimidate, entice or coerce you to sign this form. Call (415) 554-7903 if you do not understand or have any questions.

San Francisco International Airport Quality Standards Program employers are required to comply with the Healthy Airport Ordinance by either providing health benefits, making payments to City Option, or making irrevocable health care expenditures to or on behalf of covered employees. Employees may waive the employer's health plan if they complete this form and provide proof of current coverage from another health plan.

### SECTION 1. TO BE COMPLETED BY THE EMPLOYER

Employer Name: _____ Employer Representative: _____

Employer Address: _____ Employer Telephone: _____

_____ Employer Email: _____

Employee Name: _____ Employee Address: _____

Employee Telephone: _____ _____

### COMPLIANCE OPTIONS

This employer is choosing to comply with the Healthy Airport Ordinance by:
*(Please select one and provide the corresponding details)*

☐ **Option 1** – Providing a compliant Family Health Plan that meets the Department of Public Health's (DPH) health plan requirements. (*See* Section 2)

Insurance Company: _____

Plan Name: _____ Coverage Period: _____

☐ **Option 2** – Making payments to the City Option. (*City Option rate is $12.15/hour for every hour worked for each covered employee, with the rate updated annually on July 1.*) Waivers do not apply under this option.

☐ **Option 3** – Make irrevocable health care expenditures for Health Care Services to or on behalf of employee. Health care services means medical care, services or goods that may qualify as tax deductible medical care expenses under 26 U.S.C. §213, or those having substantially the same purpose or effect as such deductible expenses. Effective January 1, 2027, option 3 will be the only method to comply. (*See* Section 3)

*Please list and explain the type(s) of health care expenditure(s), e.g. premiums for medical, dental and vision insurance, reimbursement to employee for documented health expenditure, payment to a Medical Reimbursement Account, etc.*

Heath Care Expenditure Offered:

Health Plan Name: _____

Other: _____

_____

_____

### SECTION 2. WAIVER INFORMATION FOR OPTION 1

Your employer is offering you the Health Plan(s) listed under Option 1. Coverage must commence no later than the first day of the month that begins after 30 days from the start of employment. If the health plan offered by your employer satisfies DPH's health plan requirements, the employer has met their obligations under the HAO and the employer will not be obligated to provide you anything else. By signing this Voluntary Waiver Form, you are choosing to waive the Health Plan(s) offered by your employer and will not receive the employer provided health coverage during the current health plan year.



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## SECTION 3. WAIVER INFORMATION FOR OPTION 3

Your employer is offering to comply with the HAO by making Irrevocable Health Care Expenditures, as detailed in Section 1, Option 3.

You may choose to waive the health plan offered by your employer. If you opt to waive the health plan offered, your employer may apply the amount it would have spent on the health plan had you accepted coverage as a credit to offset its required health care expenditure. Your employer remains responsible for making Irrevocable Health Care Expenditures for any remaining amount not covered by the waiver. For example, if the health plan premiums exceed the required health care expenditure, your employer is not obligated to provide you anything else. If the premiums are less than the required health care expenditure based on your hours worked and household size, the employer must cover the difference through another expenditure method.

## SECTION 4. VOLUNTARY WAIVER - TO BE COMPLETED BY THE EMPLOYEE

(*only complete this section if choosing to waive health plan*)

To waive the offered health plan, you and your dependents must have health coverage from another source. By completing this form, you certify that you and your dependents have current alternate health coverage. ***If you wish to waive the health plan(s) offered by your employer, please provide the following:***

Employee Name: _____ Relationship to Subscriber:

# of Dependents: [ ] Zero [ ] One [ ] Two or more [ ] Self [ ] Child [ ] Spouse/domestic partner

Name of Health Care Plan: _____ Name of Health Administrator: _____

_____ _____

*Subscriber Information* Subscriber's Employer: _____

Subscriber's Name: _____ Employer Rep.: _____

Employer Address:_____ Employer Telephone: _____

_____ Employer Email: _____

**PROOF OF HEALTH COVERAGE**

I am currently enrolled in the health plan listed in Section 4 and am providing the following proof:
(*select one*)

- ☐ Medical Card(s) – a copy of your card and for each dependent
- ☐ Enrollment Form
- ☐ Other document showing that I/we have coverage

**NOTE: The waiver form is valid for the current health plan year; however, you may revoke the waiver if there is a qualifying life event.**

Waivers are valid only if the employer retains a fully executed waiver form and proof of current health coverage by the covered employee and dependents. Waivers are not applicable to Option 2 for City Option or for any remaining expenditures under Option 3. The waiver form is required on an annual basis.

## SECTION 5. WAIVER EMPLOYEE SIGNATURE AND ATTESTATION

**DO NOT sign this form if YOU WANT the health plan offered by your employer.**

(*only complete this section if choosing to waive health coverage*)

I certify that my dependents and I are currently receiving health benefits through another health plan. By signing this form, I understand that I am waiving my right to receive a health plan from my employer until the next open enrollment event or unless a qualifying life event occurs (i.e., loss of the health plan listed in Section 4). I hereby waive the right to the Health Plan listed in Section 1 for the current plan year. I have provided proof that my dependents and I are covered under the alternate health plan listed in Section 4.

Employee Signature: _____ Date: _____

Employee Name: _____

**If you have any questions about your employer's obligations under the Healthy Airport Ordinance, please call (415) 554-7903 or email at HCAO@sfgov.org or visit us at www.sf.gov/olse-hao**



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