CITY AND COUNTY OF SAN FRANCISCO

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

SAN FRANCISCO HEALTH CARE ACCOUNTABILITY ORDINANCE ("HCAO")
EMPLOYEE VOLUNTARY WAIVER FORM
FOR EMPLOYEES COVERED BY SFO'S QUALITY STANDARDS PROGRAM (QSP)

THIS SECTION TO BE FILLED OUT BY THE EMPLOYER:

Employee Name: _____

Employee Address: _____

_____

Employee Phone: _____

Name of Employer: _____

Employer Address: _____

Employer Contact Person: _____

Employer Telephone Number: _____

Compliant Health Plan(s) being offered to this employee and dependents without a premium charge:

Insurance Company: _____

Plan Name and Year: _____

THIS SECTION TO BE FILLED OUT BY THE EMPLOYEE:

Under the San Francisco Health Care Accountability Ordinance (HCAO), your SFO QSP employer is required to offer you with a family plan for you and your dependents that meets the health plan requirement. Your employer cannot require you to contribute any amount towards the premiums for family health plan coverage. Coverage must begin no later than March 21, 2021 or, for employees hired after that date, the first of the month that begins after 30 days from the start of employment. You may reject the employer's offer of health plan benefits; however, a rejection is valid only if the employer retains this form, signed by you, and you verify that you are receiving family health coverage.

Your employer is offering you the Compliant Health Plan(s) listed above. In order to be a Compliant Plan, it must have no premium charge to you and your dependents. This Waiver Form allows you to waive your right to receive a Compliant Health Plan from this employer. By signing this form, you are relieving your employer of the legal requirement to provide you with a Compliant Health Plan and your employer's HCAO requirements will be met. Even if you have other health insurance, your employer is required to offer you insurance or make payments unless you sign this form.

Do <u>not</u> sign this form if you want your employer to provide you with a health plan listed above. It is illegal for your employer to entice, pressure or coerce you to sign this form.

This voluntary waiver is valid for one year from the date signed.

If you wish to provide a waiver to the employer listed above, please provide the information below.

I certify that my dependents and I are currently receiving health care services from the following:

My Name:_____

Employer Providing Health Care Services:_____

Name of Employee listed on the health care benefit:_____

Relationship to that employee: [ ] Self [ ] Child [ ] Spouse/domestic partner

Name of Health Care Plan and Administrator:_____

Employer Address:_____

Employer Contact Person:_____

Employer Telephone:_____

Employer:_____

Email:_____

I have attached proof that I have the above health plan with a copy of:

☐ Medical Card(s) – a copy of you card and for each dependent

☐ Enrollment Form

☐ Other document that shows proof that I/we have the plan listed above

I certify that my dependents and I are receiving health care services from the above-named employer through my own employment, or through my spouse/partner/parent's employer. By signing this form, I understand that I'm giving up my right to receive a family health plan from my employer named on page one of this form until the next open enrollment event or if there is a qualifying life event (i.e. loss of the health plan state above). I hereby waive the right to the Compliant Health Plan listed above offered to me by the employer listed above for the current plan year. I have provided proof that my dependents and I have the health plan listed above.

Employee Signature: _____ Today's Date: _____

Employee Name: _____