



Certification Form for Waiving Health Plan Coverage

Employee Name: _____

ID #: _____

☐ Medical Plan

I elect not to enroll in medical insurance through the County for the 2026 Plan Year.
I certify that I and all of my tax dependents have other group medical insurance coverage that provides minimum value within the meaning of the Affordable Care Act. I understand that this certification will be required for every Plan Year for which I waive the County's medical insurance coverage.

Employee Initials: _____

Name of outside plan: _____ Group #: _____ Effective Date: _____

My outside plan is:

- ☐ My spouse's employer's group medical insurance plan
- ☐ My parent's employer's group medical insurance plan
- ☐ Other group medical insurance plan

☐ Dental Plan

Name of outside plan: _____ Group #: _____ Effective Date: _____

☐ Vision Plan

Name of outside plan: _____ Group #: _____ Effective Date: _____

☐ I have attached proof of other coverage **for each type of insurance for which I am requesting a waiver**, in the form of a membership card, or letter from the applicable employer.

I understand that if I lose enrollment in my outside plan, I must notify Human Resources within 30 days of that loss, and I must immediately enroll in Tuolumne County plans.

Employee Initials: _____

Employee Signature: _____ Date: _____

Human Resources 209.533.5566
Fax 209.533.5901