Sacramento City Unified School District

OFFICE OF RISK MANAGEMENT/EMPLOYEE BENEFITS
5735 47th Avenue - Sacramento, CA 95824
Risk Management Main: (916) 643-9421
Employee Benefits Main: (916) 643-9432
Disability Management Main: (916) 643-7895
Fax: (916) 399-2071
Keyshun Marshall, *Director II*

SUBJECT: Cash in Lieu

TO: All Eligible Health Members

DATE: September 27, 2022

The district is now offering a cash-in-lieu incentive for SCTA employees who would like to waive their health benefits. The $250 "cash in lieu" benefit will be added to district monthly compensation. Complete the Health Benefits Waiver form including proof of coverage and submit to Benefits@scusd.edu electronically, in person or by fax to (916) 399-2071.

Enrollment in the Sun Life insurance can still be elected if waiving health, vision and dental benefits. Complete and return the Sun Life beneficiary form with the Health Benefits Waiver form.
This waiver is only effective for one year with an end date of December 31st. A new waiver will need to be completed every year during Open Enrollment.

Please remember the following items:

- Health Benefits Waiver Form
- Proof of Coverage (*Not required if insured by another SCUSD employee*)
- Sun Life Beneficiary Form (*optional*)

Please contact our office at (916) 643-9432 if you have any questions or send documents to Benefits@scusd.edu.

Sincerely,

Employee Benefits

Sacramento City Unified School District

Health Benefit Waiver

Confirmation of Alternative Group Plan Coverage

Who is eligible to Waive Benefits (check applicable):

☐ *Active Employees in CSA, UPE or Unrepresented groups in permanent positions with other group coverage.*

☐ *Active SEIU, SCTA, and Teamster members with other group coverage.*

☐ *Retired SCTA members over 65 with Medicare A and/or B, with dual Medicare health coverage.*

☐ *Retired CalSTRS or CalPERS member with other group coverage.*

☐ *Retired Teacher Opt Out Program.*

(Please print)

Name: _____ _____ _____ _____
(Last) (First) Middle Initial Date of Birth

_____ Phone: _____ _____
Social Security Number (Area Code)

Current Year: _____ Status: ☐ Active ☐ Retired ☐ PERS ☐ STRS

I currently have alternative coverage in the following group medical plan provided by an employer through December 31 of this year and accordingly elect to waive coverage through Sacramento City Unified School District.

_____ _____
Name of Insured Employer

_____ _____
Insured's Social Security Number Medical Plan and Group Number

I affirm that the information given above for alternative group medical benefit coverage is a true and valid statement.

I understand that this waiver is only effective for one year, currently ending December 31. **I also understand that I need to complete a new waiver every year during Open Enrollment, to keep my waiver valid.** Unless a completed waiver with proof of coverage is provided by the close of the open enrollment period, I will be automatically enrolled in the least costly medical plan.

If the above referenced medical plan is terminated, for any reason prior to December 31, I shall provide immediate written notification to the Employee Benefits Office within 30 days of termination. The loss of coverage may be a qualifying event allowing enrollment in a CalPERS/District Health Plan, without waiting for an open enrollment period. If I fail to do so within 30 days or the termination does not constitute a Qualifying Event, I shall be solely responsible for obtaining and paying for health benefit coverage until the next Open Enrollment period.

By waiving my right to active participation in the CalPERS/District insurance plans, I in no way hold the Sacramento City Unified School District responsible for any claims or costs that would otherwise be covered by these plans, and/or any limitation or exclusions that may be placed upon my coverage by these plans if and when I reenroll as a participant. I understand I cannot enroll as a participant in the CalPERS/District insurance plans I have waived until the next Open Enrollment period, unless there is a qualifying event.

This confirmation of Alternative Group Plan coverage is only effective if proof of other coverage is attached. Such proof of coverage shall be provided in a manner acceptable to Sacramento City Unified School District.

My signature below is acknowledgement that I have read and understand the consequences of this waiver. I have had the opportunity to consult with an employee representative or attorney.

_____ _____
Signature Date

Employee Benefit Office • 5735 47th Avenue • BOX 840B • Sacramento, CA 95824 • 916-643-9432 • 916-399-2071 FAX

Sacramento City Unified School District

SACRAMENTO CITY UNIFIED SCHOOL DISTRICT
Sun Life Insurance
PLEASE USE BLUE OR BLACK INK ONLY

Effective Date _____

☐ New Enrollment ☐ Name Change/Former Name _____
☐ Open Enrollment ☐ Beneficiary Change / Update ☐ Address Change

Employee's Last Name	First Name, Middle Initial	Date of Birth	Social Security #
		- -	- -
Street/Mailing Address	City, State, Zip		Hire Date
			/ /

Male / Female	Non-Certificated Voluntary Life	Management Life Insurance
☐ Single ☐ Married ☐ Widowed ☐ Divorced	Accept ☐ Decline ☐ At employee cost, $7.92 per month Max $15,000.00 Available upon hire or elect or delete during Open Enrollment	**UPE, CONF, UNREP MGMT $125,000** Automatic enrollment unless a voluntary waiver is requested

Primary Beneficiary

Last Name, First Name M	DOB	Relationship	Social Security #
	/ /		
Telephone Number		Email Address	
Street Address/Mailing Address		City	State Zip

Last Name, First Name M	DOB	Relationship	Social Security #
	/ /		
Telephone Number		Email Address	
Street Address/Mailing Address		City	State Zip

Last Name, First Name M	DOB	Relationship	Social Security #
	/ /		
Telephone Number		Email Address	
Street Address/Mailing Address		City	State Zip

Secondary Beneficiary

Last Name, First Name M	DOB	Relationship	Social Security #
	/ /		
Telephone Number		Email Address	
Street Address/Mailing Address		City	State Zip

In order to be covered under the Life Insurance policy, I understand that I must be either actively at work, or a former eligible employee who retired under CalSTRS or CalPERS. If I am not actively at work when the group life insurance policy becomes effective, my coverage will commence on the date I return to active work. I will be required to submit a new enrollment application at that time. For additional information, refer to Sun Life Certificate of coverage.

MY SIGNATURE BELOW IS ACCEPTANCE OF THE POLICY TERMS. I UNDERSTAND THAT THIS FORM DOES NOT MODIFY ANYTHING ON MY ORIGINAL ENROLLMENT APPLICATION EXCEPT AS I HAVE INDICATED ON THIS FORM.

_____ _____
Employee's or Retiree's Signature Date Signed