Retiree Cash Payment in Lieu of Medical Insurance Election Form

I certify that I am a retiree of the Contra Costa Community College District (CCCCD) living outside of areas served by the District's medical insurance plans and I am entitled to medical coverage as a retiree based on Human Resources Policy 1120.07.

I am electing a cash payment in lieu of medical insurance and have submitted evidence I have secured other medical insurance outside of CCCCD that is at least equivalent to the medical insurance provided by the CCCCD for myself and dependents (if applicable). I understand that the cash payment in lieu of medical insurance will not be implemented until the appropriate documentation has been received and verified by the CCCCD Payroll Department.

As a result, I elect to waive my medical insurance benefits through the CCCCD and receive a monthly amount in taxable earnings. As a consideration for the above-mentioned cash payment, I hereby release the District from any responsibility or liability for providing me or dependents (if applicable) with medical insurance.

I understand and agree that it will be my responsibility to continue medical insurance at my own expense. By signing this agreement, I understand the cash election MAY NOT BE CHANGED except for the following reasons:

1. CCCCD annual open enrollment
2. Loss of medical coverage (30 day window to enroll in a CCCCD medical insurance)
3. A move back into a service area

I have attached evidence of other coverage to this document.

Retiree Information

Employee ID _____

First Name _____ Last Name _____

Social Security Number _____-_____-_____ Birthdate _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

_____ _____

Signature *Date*

Return to: District Office, Payroll Department, 500 Court Street, Martinez CA 94553.

Updated 11/27/2018