Contra Costa Community College District

Employee Name: _____

Employee ID #: _____ Campus: _____

Cash Election

I acknowledge that **I Have Submitted an Affidavit of Other Health Insurance Coverage** and consequently elect to waive my Health Insurance benefits through the Contra Costa Community College District. By waiving this benefit, I understand that I will receive a monthly amount in taxable earnings equal to the Kaiser single rate effective during the term of this agreement.

This agreement will not be implemented until the appropriate documentation has been received and verified.

Election Authorization

By signing this agreement, I understand the following provisions:

The above election ***may not be changed*** except during Open Enrollment, or upon a change in my family status such as:

- Marriage/Divorce
- Birth/Death
- Commencement/Termination of Spouse's Employment Change in Employment Status, the employee or spouse Taking an unpaid Leave of Absence; or a significant change in the Health Coverage of the Employee or Spouse.

Election changes must be made within 30 days of the event.

Written notification must be received in district payroll services in order to terminate this election.

_____ _____

Employee Signature Date

Please note: Cash election will not start until the first of the month after the date of signature.