Contra Costa Community College District

Waiver of Medical Insurance

Employee Name: _____

Employee ID #: _____ Campus: _____

As an employee of the Contra Costa Community College District, you are entitled to participate in District-sponsored medical insurance for you and your eligible dependents. A summary of the available medical plans is available on the District website.

Waiver Agreement:

- I understand that I have the right to decline medical insurance offered to me by the Contra Costa Community College District.
- I acknowledge that by electing to waive medical insurance, I will not be eligible to enroll in District-sponsored medical benefits until the next open enrollment period, or I experience a qualifying event.

I hereby waive District-sponsored medical insurance, effective immediately, offered to me by the Contra Costa Community College District.

_____ _____

Employee Signature Date