REQUEST FOR CERTIFICATE OF HEALTH COVERAGE

Employee Name ___________________________________________  Employee ID #________________

My spouse’s employer requires written verification of their coverage as my dependent under the San Diego Unified School District’s group health plan. Please mark only one box below and provide your signature under the statement selected:

☐ My spouse does not receive a cash benefit to waive medical coverage under their employer’s plan:

_________________________________________   _____________________
Signature of Employee                               Date

☐ My spouse does receive a cash benefit to waive medical coverage under their employer’s plan:

Authorization: I understand that in the event my spouse waives medical coverage through another employer, in exchange for a cash payment, terms in the bargaining unit contract (excludes AASD represented and unrepresented positions) require the district to deduct $100/month from each of the (10) monthly paychecks issued to me from September to June. This is an after-tax deduction and will remain in force for as long as my spouse continues to receive cash in lieu of benefits from their employer.

_________________________________________   _____________________
Signature of Employee                               Date

Please let us know how we should deliver the Certificate of Coverage:

☐ Email ___________________________________________

☐ Call for Pickup ________________________________

☐ Mail __________________________________________

☐ Fax ____________________________________________

Return the completed request to the Employee Benefits Department. Please allow up to 7 business days for processing.

Employee Benefits Department
4100 Normal St Room 1150
San Diego, CA 92103
Ph: (619) 725-8130 Fax: (619) 725-8132
Email: employeebenefits@sandi.net