PERRIS UNION HIGH SCHOOL DISTRICT
155 East 4th Street
Perris, CA 92570
Telephone: 951.943.6369

DUPLICATE MEDICAL COVERAGE VERIFICATION FORM

EMPLOYEE NAME: _____
(PLEASE PRINT)

EMP ID#:_____CERTIFICATED:_____CLASSIFIED:_____

NAME OF INSURANCE:_____

GROUP or POLICY #:_____

INSURANCE GROUP PHONE #:_____

Please include a copy (front & back) of your current medical card.

Full-time employees and employees taking medical benefits with District are required to have the District dental and vision insurance coverage. Benefit eligible employees who provide proof of duplicate medical coverage during the Open Enrollment Process of each fiscal year or within 30 days of their hire date or life event shall be eligible to receive cash in lieu of District medical coverage for that fiscal year. It is the employee's responsibility to inform Employee Benefits within 30 days of any change of status, i.e., termination of other medical insurance coverage. Employees could be responsible for repaying the District if they are receiving Cash Option and they do not meet the requirements. Medical coverage may be verified by Employee Benefits.

I understand the District has offered me and my eligible dependents affordable medical insurance that provides minimum essential coverage and meets the minimum value standards and I am electing to waive that coverage. The medical, dental and vision plan summary of benefits and coverage as well as costs are located on the district website at https://www.puhsd.org/pages/2019-2020-rate-calculators and can be viewed at any time.

EMPLOYEE SIGNATURE:_____DATE:_____

FOR BENEFITS DEPARTMENT USE ONLY

School Yr_____Verified_____Effective Date_____

Annual Cash Option $_____Divided by_____Payments = $_____Per Pay Period.