PERRIS UNION HIGH SCHOOL DISTRICCT
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.

ALL Full-time employees and employees taking medical benefits with District are required to have the District Dental and Vision Insurance coverage. 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** 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 or change in marital status. 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 medical insurance and I am electing to waive that coverage.

EMPLOYEE SIGNATURE:_____DATE:_____

FOR BENEFITS DEPARTMENT USE ONLY

School Yr_____Verified_____Effective Date_____

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