DUVAL COUNTY
PUBLIC SCHOOLS

Declination of Healthcare Coverage Affidavit

I hereby certify that:

1. I am eligible and have been given an opportunity to fully participate in the group medical plans provided by Duval County Public Schools (DCPS Medical Plan).
2. The benefits of the medical plans have been thoroughly explained to me and I decline to accept that offer to participate. My Declination will remain in effect for future Plan Years unless I re-enroll as outlined below.
3. I understand that I will not be enrolled in a DCPS Medical Plan. I will receive $10,000 Group Term Basic Life/AD&D Insurance and a prorated annual amount of $250 Flex Basic Dollars to defray the cost of voluntary pretax benefits (excluding life insurance) and a prorated annual amount of $1,200 post tax benefit that will be treated as taxable income.
4. I understand that I may re-enroll into the DCPS Medical Plan only during an annual open enrollment period as determined by the School Board of Duval County, FL or during a "special enrollment period" (Change in Status). A "special enrollment period" is a period of time during which you may be able to elect to enroll yourself and/or dependents after one of the following events occurs:
    - **Loss of other medical insurance coverage** – You may be able to enroll yourself and/or your dependent(s) provided that you request enrollment within **sixty (60) days** after such other coverage ends. In the case of COBRA continuation coverage, you may be eligible for a special enrollment period if the COBRA coverage is exhausted. A special enrollment period is not available if coverage under your prior plan or COBRA coverage was terminated for failure to timely pay the required premiums.
    - **Acquiring a new dependent** – If you acquire a new dependent as a result of marriage, birth, adoption or placement for adoption you may be able to enroll yourself and/or your dependents provided that you request enrollment within **sixty (60) days** after the date of marriage, birth, adoption or placement for adoption.
5. I intend to enroll or am currently enrolled in another employer group medical plan, a government sponsored medical plan, or the health insurance marketplace.

I have read, understand and agree to comply with the requirements stated above. **Mid-year**: changes are effective the first day of the month following receipt of this completed form. **Open Enrollment:** changes are effective January 1.

Employee Name (Print): _____ Confirmation #:_____

Employee Signature: _____ Date: _____

Benefit Representative: _____ Date: _____

Return form to:
DCPS Employee Benefits Department, 1701 Prudential Dr., Ste. 209 Jacksonville, FL 32207
Phone: 904-390-2351 Fax: 904-390-2370

This Affidavit must be signed and completed along with your benefit enrollment form.