EMPLOYEE VOLUNTARY WAIVER FORM

Effective 2008, San Francisco law requires your employer to make health care expenditures on your behalf. A health care expenditure is an amount of money paid by your employer to you or to a third party for the purpose of providing you with access to health care services. For example, your employer may:

- make payments to enroll you in a health insurance program,
- reimburse you for the costs of health care services you get on your own,
- make payments on your behalf to the City's new *Healthy San Francisco* program, or
- establish and maintain a reimbursement account for your health care expenses.

You have been asked to complete this Voluntary Waiver Form because your employer is requesting a waiver from the legal requirement described above. Your employer may obtain a waiver from this legal requirement if you are currently receiving health care services through another employer, either as an employee of that other employer or by virtue of being the spouse, domestic partner, or child of a person employed by that employer. To support a waiver request, your employer must obtain a new signed Voluntary Waiver Form from you each year, updated as necessary to reflect any changes to the information provided.

Even if you receive health care services through another employer, you are entitled to receive health care services from this employer. If you sign this form, your employer may stop making a mandatory health care expenditure to you or on your behalf. If you want your employer to provide you with access to health care services, do **not** sign this form. It is illegal for your employer to force or to pressure you to sign this form.

You have the right to cancel or revoke this voluntary waiver at any time. Your revocation must be submitted in writing. If you revoke this waiver, your employer will be required to make health care expenditures to you or on your behalf.

Employee Name: ________________

Employee Address ________________

Name of Employer Requesting Waiver: _______________

Employer Address: _________________________________

Employer Contact Person: ______________________

Employer Telephone No.: ____________________

I hereby certify that I receive health care services through another employer or through my spouse, domestic partner, or parent(s), as indicated below:

If you receive health care services through another employer whom you work for and wish to provide a waiver to the employer listed above, please provide the information below:

Name of Employer Providing Health Care Services:

____

Employer Address: __________________________

Employer Contact Person: ____________________

Employer Telephone No.: _____________________

Type of Coverage Provided to You (check one):

□ health insurance (*provide name of provider below*)

____

□ SF HAP/*Healthy San Francisco*

□ reimbursement/direct payment of health care expenses

□ other (*describe*) ________________________________

If you receive health care services through the employer of your parent, spouse, or domestic partner and wish to provide a waiver to the employer listed above, please provide the information below:

Name of Person Whose Coverage Extends to You:

____

His/Her Relationship to You: ________________

Name of His/Her Employer _________________

His/Her Employer Address: _________________

Employer Contact Person: __________________

Employer Telephone No.: __________________

Type of Coverage Provided to You (check one):

□ health insurance (*provide name of provider below*)

____

□ SF HAP/*Healthy San Francisco*

□ reimbursement/direct payment of health care expenses

□ other (*describe*) _____________________________

I hereby waive the right to the health care expenditures described above, made to me or on my behalf by the employer listed above.

____________________________ Employee's Signature

____________________________ Today's Date

If you have any questions about your employer's obligations under the Health Care Security Ordinance, please call 554-7892 or visit www.sfgov.org/olse/hcso.

Para asistencia en Español, llame al 554-7892.
需要中文幫助，請電 554-7892.

Complete this section ONLY if you wish to revoke a Voluntary Waiver Form that you have signed and provided to your employer. *If you wish to waive your right to health care expenditures made to you or on your behalf by my employer, do NOT complete the portion below.*

REVOCATION OF VOLUNTARY WAIVER FORM

I no longer wish to waive the right to health care expenditures made to me or my behalf by my employer, pursuant to the San Francisco Health Care Security Ordinance.

____________________________ Employee's Signature

____________________________ Today's Date