Seventh-day Adventist Church
SOUTHEASTERN CALIFORNIA CONFERENCE

HUMAN RESOURCES

HEALTH CARE BENEFITS EMPLOYEE WAIVE BENEFITS FORM

First Name: _____

SSN: _____
(Last 4 numbers)

Effective: _____

Check one box only

☐ **I am covered under a SECC Southeastern CA Conference** employee healthcare plan (via spouse or parent), I can't receive the $150 opt-out benefit. If my coverage changes due to personal circumstances or aging out, I'll contact the SECC HR Department to enroll for continued benefits.

☐ **I have alternative medical coverage and elect to waive all SECC healthcare benefits** (Adventist Risk Management–Ascend to Wholeness, Kaiser, Delta Dental, and HCAP) in exchange for the $150 monthly opt-out payment. I confirm that I have health coverage through another source (e.g., spouse, parent, Medicare, or Medicaid) and have attached proof of this coverage as required. I understand that:

- My spouse and dependent children will not be eligible for SECC benefits.
- Future enrollment may be limited to SECC's open enrollment period or a qualifying life event as outlined in the Plan.

☐ **I acknowledge that my medical coverage is through Medicare**, making me ineligible for the $150 opting-out benefit from SECC medical coverage. Additionally, I am not altering my medical coverage with my employer.

☐ I have alternate medical coverage but would like to elect Delta Dental and/or HCAP (vision) benefits through SECC. I understand that by selecting dental and/or vision coverage, I will not receive the $150 monthly opt-out payment. I have attached proof of my alternate medical coverage as required.

Please check all that apply:

☐ Elect Delta Dental only
☐ Elect HCAP (Vision) only
☐ Elect both Delta Dental and HCAP (Vision)

_____ _____

Employee Signature Date