PROOF OF OTHER COVERAGE STATEMENT

If you are waiving medical coverage with Lane County, you are required to maintain other group medical coverage and provide documentation thereof upon request.

If you have elected to waive medical coverage, you must complete this form and sign the statement below.

I have current medical coverage under another plan as indicated below.

1. Source of other coverage (other employer's name):

   _____

2. Name of the insurance company or organization providing the coverage:

   _____

3. Insurance policy or group number:

   _____

I understand that by exercising this election to waive medical coverage I will receive no benefits or coverage from any Lane County group medical plan, and that if I wish to enroll in any of Lane County's medical plans at a later date I will be subject to that plan's enrollment and eligibility rules. I further understand that making false statements on this form or failing to provide proof of other coverage, if so requested, shall constitute grounds for disciplinary action, up to and including termination of employment.

I certify that the above information is true and correct as of the date indicated below.

Dated: _____

_____ _____

Print name (last, first, middle initial) Employee ID #

_____

Employee signature

Please note that if you decline medical insurance enrollment for yourself or your dependents because of other group insurance coverage, you may in the future be able to enroll yourself or your dependents, provided that you request enrollment within 31 days after the loss of that other coverage. In addition, if you have a new dependent as a result of marriage, birth or adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth or adoption.