San Francisco HCSO Voluntary Waiver Cover Page

You must complete and sign both pages of the Health Care Security Ordinance Employee Voluntary Waiver Form.

By completing the Health Care Security Ordinance Employee Voluntary Waiver Form on the following page, Robert Half will not make required HCSO contributions on your behalf to either the San Francisco Indemnity Plan or City Option.

Each year you must reaffirm your choice to voluntarily waive by completing this form. You can revoke your voluntary waiver at any time.

Mail or Fax completed form to:

MAIL:
RH HCSO Processing Team
11910 Anderson Mill Rd., Suite 401
Austin, TX 78726

FAX:
1-800-713-0294

HEALTH CARE SECURITY ORDINANCE EMPLOYEE VOLUNTARY WAIVER FORM

Updated November 1, 2017

ATTENTION EMPLOYEES: IF YOU COMPLETE THIS FORM, YOU ARE GIVING UP YOUR RIGHT TO RECEIVE HEALTH CARE SERVICES FROM THIS EMPLOYER

- **You do not have to sign this form. It is unlawful for your employer to pressure you to sign this form. Signing this form may make you ineligible for health benefits you would otherwise be entitled to.**
- **Read the form carefully. If you have any questions about this form or your employer's obligations under the Health Care Security Ordinance, please call 415-554-7892 or visit www.sfgov.org/olse/hcso. Para asistencia en español, llame al 415-554-7892. 需要中文幫助，請電 554-7892**

The San Francisco Health Care Security Ordinance requires this employer to make health care expenditures on your behalf, even if you already have health insurance and/or receive health care services from another employer. A health care expenditure is an amount of money paid by your employer to provide you with access to health care services. For example, your employer may:

- make payments to enroll you in a health insurance program,
- make payments on your behalf to the City Option program (MRA or Healthy San Francisco), and/or
- establish and maintain a reimbursement account for your health care expenses.

Your employer may request that you waive its legal obligations to spend money on health care services for you if you are currently receiving health care services from another employer. Your employer must obtain an updated and signed Voluntary Waiver Form from you each year that you agree to waive its legal obligations. **Even if you receive health care services through another employer** (ie, your other job, your spouse/domestic partner/parent's job)**, you are entitled to receive health care services from THIS employer.** If you sign this form, you are telling this employer it can stop making a mandatory health care expenditure on your behalf **Even if you choose to sign this form, you have the right to revoke or cancel it at any time.**

ARE YOU ELIGIBLE TO WAIVE HEALTH CARE SERVICES?

Examples of Employees who should not sign this waiver are:

- Employees who do not receive healthcare services from another employer
- People who pay for their own insurance out of pocket, or whose families pay for their insurance;
- People who are uninsured;
- Medi-Cal recipients;
- Participants in county-run medical programs (ie, San Mateo County Health Plan, Health PAC (Alameda Co.), etc.

If you have questions about whether you are eligible to sign this waiver, please call 415-554-7892.

I acknowledge that I have read the above statement.

Employer Name: _____

Employee Name: _____

Today's Date: _____

HEALTH CARE SECURITY ORDINANCE EMPLOYEE VOLUNTARY WAIVER FORM

ATTENTION EMPLOYEES: THIS FORM CONSISTS OF 2 PAGES. IF YOU DID NOT RECEIVE 2 PAGES, DO NOT SIGN THIS FORM.

I certify that I am currently receiving health care services from the employer named below:

My Name	
Employer Providing Health Care Services	
Name of Employee listed on the health care benefit	
Relationship to that employee	[ ] Self [ ] Child [ ] Spouse/domestic partner
Type of Health Care Benefit and Administrator (Insurance Provider or Benefits Administrator)	
Employer Address	
Employer Contact Person	
Employer Telephone Employer Email	

I certify that I am receiving health care services from the above named employer through my own employment, or through my spouse/partner/parent's employer.

By signing this form, I understand that I'm giving up my right to receive health care services from my employer named on page one of this form for a period of one year. I will provide my employer proof of my healthcare services from another employer.

Employee Signature: _____ Today's Date: _____

Employee Name: _____ Effective Date: _____
(effective date cannot be before today's date and must be within four months of today's date)

EMPLOYEE REVOCATION OF VOLUNTARY WAIVER FORM

Complete this section ONLY if you wish to revoke (cancel) 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 your employer, do NOT complete the portion below. Please note that you have the right to revoke this voluntary waiver form at any time. You do not have to give your employer a reason for revoking this waiver form. Your revocation must be in writing, and is effective immediately.*

REVOCATION OF VOLUNTARY WAIVER FORM

I no longer wish to give up my right to health care expenditures made on my behalf by my employer named on page one of this form.

Employee Signature: _____

Employee Name: _____ Today's Date: _____

Employer and employees should keep a copy of this form.