GENERAL SERVICES AGENCY
OFFICE OF LABOR STANDARDS ENFORCEMENT
DONNA LEVITT, MANAGER

SAN FRANCISCO HEALTH CARE ACCOUNTABILITY ORDINANCE ("HCAO")
EMPLOYEE VOLUNTARY WAIVER FORM

THIS SECTION TO BE FILLED OUT BY THE EMPLOYER:

Employee Name: ______________________ Name of Employer: _______________________________________

Employee Address: ______________________ Employer Address: _______________________________________

______________________ Employer Contact Person: _________________________________

Employee Phone: ______________________ Employer Telephone Number: ______________________________

Compliant Health Plan(s) being offered to this employee without a premium charge:

Insurance Company: ____

Plan Name and Year: ____

THIS SECTION TO BE FILLED OUT BY THE EMPLOYEE:

Under the San Francisco Health Care Accountability Ordinance (HCAO), your employer is required to (1) offer you a health insurance plan that meets the HCAO Minimum Standards (available at sfgov.org/olse/hcao) and that does not require you to contribute any part of the premium (referred to here as a "Compliant Health Plan"); or (2) make payments to the City; or (3) under limited circumstances, make payments directly to you. You may reject the employer's offer of health plan benefits; however, a rejection is valid only if the employer retains this form, signed by you, and you verify that you are receiving health coverage.

Your employer is offering you the Compliant Health Plan(s) listed above. In order to be a Compliant Plan, it must have no premium charge to you for individual coverage. This Waiver Form allows you to waive your right to receive a Compliant Health Plan from this employer. By signing this form, you are relieving your employer of the legal requirement to provide you with a Compliant Health Plan. Even if you have other health insurance, your employer is required to offer you insurance or make payments unless you sign this form.

Do not sign this form if you want your employer to provide you with a health plan listed above. **It is illegal for your employer to entice, pressure or coerce you to sign this form.**

This voluntary waiver is valid for one year from the date signed.

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 provide health insurance to you or make payments.

If you wish to provide a waiver to the employer listed above, please provide the information below:

I hereby certify that:

☐ I am enrolling in another plan that is being offered to me by this employer (other than one listed above)

OR

☐ I already have the following health insurance coverage from a different company or source:

____

I hereby waive the right to the Compliant Health Plan listed above offered to me 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 Accountability Ordinance, please call 554-4791 or visit www.sfgov.org/olse/hcao.

Para asistencia en Español, llame al 554-4791. **需要中文幫助，請電 554-4791.**

COMPLETE THE FOLLOWING SECTION ONLY IF YOU WISH TO REVOKE A WAIVER PREVIOUSLY GRANTED TO YOUR EMPLOYER. *If you wish to waive your right to the compliant health plan(s) listed above, do NOT complete the portion below.*

REVOCATION OF HCAO VOLUNTARY WAIVER FORM

I no longer wish to waive the right to health insurance offered to me by the employer listed above, pursuant to the San Francisco Health Care Accountability Ordinance.

______________________________ ______________________________
Employee's Signature Today's Date