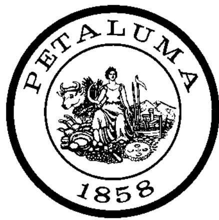

City of Petaluma

HUMAN RESOURCES

Cash In-Lieu Health and Dental Benefits Enrollment & Cancellation Form

Employee Information

Employee Name	Department	Employee Number

Election of Cash in-Lieu (select below):

I am eligible for the following level of coverage:

☐ Employee Only ☐ Other
☐ Employee + 1
☐ Employee + 2 or more

I elect to decline the following coverage (choose one):

☐ Medical Only
☐ Medical and Dental

Please list all dependents for which you are eligible to receive Cash In-Lieu:

Dependent Name (please list all eligible)	Relationship to Employee	Date of Birth

Name of Medical Plan	Name of Dental Plan (if applicable)	Effective Date of Coverage	Is the coverage current and continuous? ☐ Yes ☐ No	

- I have attached written proof of medical and or dental coverage from a source outside the City.
- I understand that I will be required to complete and submit a recertification form each Open Enrollment period as designated by the City.
- This benefit is elective and is subject to the terms and conditions under my MOU/Compensation Plan.
- I certify that I (and any eligible dependents) have health coverage under the health benefit plan as listed above. I further certify that all information and documentation provided are true and accurate. I understand that any false, deceptive or otherwise improper representation may result in the cancellation of my participation in the Cash In-Lieu program.

Employee Signature	**Date**

Human Resources Use

Dependent documentation: ☐ Received Written proof of coverage: ☐ Received Effective date:

Approved by: ____ Date: ____________________

Cancellation of Cash In-Lieu Benefit: Effective Date ________________

- I elect to cancel the cash in-lieu benefit and have provided the appropriate forms indicating loss of health and dental coverage to the Human Resources office.
- I have filled out the health and/or dental enrollment forms.
- I understand that this cancellation will reduce my gross earnings at the next available pay period.

Employee Signature	**Date**

Human Resources Use

Dependent documentation: ☐ Received Written proof of coverage: ☐ Received Effective date: ☐

Approved by: ____ Date: ____________________________