

# LWO – EMPLOYEE BENEFITS WAIVER APPLICATION

OCC APPROVAL REQUIRED

**This application for waiver must be submitted by Employees along with the required documents. INCOMPLETE SUBMISSIONS WILL BE RETURNED.**

## TO BE FILLED OUT BY THE EMPLOYEE:

1. Employee Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_
2. Employee Address: \_\_\_\_\_
3. Employer Name: \_\_\_\_\_
4. Do you work for a Subcontractor?  Yes  No If YES, state the name of your Prime Contractor: \_\_\_\_\_

## SECTION I: WAIVER INFORMATION

During the duration of any City of Los Angeles (City) contract which is subject to the Living Wage Ordinance, employees working on this contract are entitled to health benefits, if offered by the employer.

## SECTION II: BENEFIT INFORMATION

By completing this form, I understand the following (check off all boxes):

- I am waiving health benefits from my Employer which could include health, dental, vision, mental health, and disability income.
- Should I need benefits from my Employer in the future, I will only be able to elect benefits during annual Open Enrollment or in the event that I experience a qualifying life changing event.
- I understand that an approved waiver does not require my Employer to waive the company's health benefits plan for me.
- I am not entitled to the hourly rate without health benefits pursuant to Section 10.37.2. Your employer is required to pay a minimum wage of \$11.27 per hour for employees and \$11.68 per hour for employees working at the airport.**
- I am eligible for benefits under another health plan in which my spouse, domestic partner or parent is a participant or subscriber.

## SECTION III: DOCUMENTATION

The health plan I am covered under is:  My spouse (S)  My domestic partner (DP)  My parent (P)

Please provide a copy of your insurance card and your S/DP/P's insurance card, and one of the following documentation to prove you are covered under a spouse, domestic partner or parent's health plan:

- Statement from S/DP/P's insurer  Statement from S/DP/P's employer  Other \_\_\_\_\_

## SECTION IV: SIGNATURE

By signing, the Employee certifies under penalty of perjury under the laws of the State of California that the information submitted in support of this application is true and correct to the best of the employee's knowledge.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

**ANY APPROVAL OF THIS APPLICATION EXEMPTS ONLY THE LISTED EMPLOYEE FROM THE HEALTH BENEFITS PROVISIONS OF THE LWO FOR 12 MONTHS AND DURING THE PERFORMANCE OF THIS CONTRACT.**

## OCC USE ONLY:

Approved / Not Approved – Reason: \_\_\_\_\_

By Analyst: \_\_\_\_\_ Date: \_\_\_\_\_