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: _____

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 provided 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 eligible for benefits under another health plan in which my spouse, domestic partner or parent is a participant or subscriber and/or I receive health benefits through a Federal Medicare/ Department of Veteran Affairs Insurance Program.

☐I understand if approved, that my employer is required to provide $100 a month to Full Time employees and $50 a month to Half Time employees 10.37.15(e)(1)(2). *Considered Full Time if employee works at least 30 hours a week or 130 hours a month. Considered Half Time if employee works less than 30 hours a week or less than 130 hours a month.

SECTION III: DOCUMENTATION

1) I am covered under the health plan of: ☐ My spouse (S) ☐ My domestic partner (DP) ☐ My parent (P) ☐Medicare ☐ Dept. Of Veteran Affairs

2) Please provide a copy of your insurance card. In addition, please provide one of the following documents to prove you are covered under a spouse, domestic partner, parent's health plan OR through Medicare/ Dept. of Veteran Affairs:

☐Statement from S/DP/P's insurer ☐Statement from S/DP/P's employer ☐Tax Form 1095-B ☐Evidence of Coverage Letter from Medicare/ Dept. Veteran Affairs ☐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:** _____