EMPLOYEE VOLUNTARY WAIVER FORM

Updated October 30, 2014

ATTENTION EMPLOYEES

- **You do not have to sign this form. It is unlawful for your employer to pressure you to sign this form. It is your choice—there is absolutely no requirement that you sign this form.**
- **It is important that you read both pages of this form.**
- **If you have any questions about this form or your employer's obligations under the Health Care Security Ordinance, please call 554-7892 or visit www.sfgov.org/olse/hcso. Para asistencia en Español, llame al 554-7892. 需要中文幫助，請電 554-7892.**

The San Francisco Health Care Security Ordinance requires your employer to make health care expenditures on your behalf. A health care expenditure is an amount of money paid by your employer for the purpose of providing you with access to health care services. For example, your employer may:

- make payments to enroll you in a health insurance program,
- reimburse you for the costs of health care services you get on your own,
- make payments on your behalf to the City's *Healthy San Francisco* program, or
- Establish and maintain a reimbursement account for your health care expenses.

Your employer may request a waiver from this legal requirement if you are currently receiving health care services from another employer. To support a waiver request, your employer must obtain a signed Voluntary Waiver Form from you each year, updated as necessary to reflect any changes to the information provided.

Even if you receive health care services through another employer, either as an employee of that other employer or by virtue of being the spouse, domestic partner, or child of a person employed by that employer, you are entitled to receive health care services from this employer also. If you sign this form, your employer asking for this waiver may stop making a mandatory health care expenditure on your behalf. **If you want your employer to provide you with access to health care services, do not sign this form.**

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 listed below will be required to make health care expenditures on your behalf.

Employee Contact Information	Employer Contact Information
Name:	Company Name:
Home Address:	Employee Worksite Address:
Tel:	Contact Person:
Email:	Tel:

If you wish to give up your right to receive health care contributions from your employer, you must fully complete the section on the next page. This waiver form is valid for one year. Once this waiver form expires, or you revoke this waiver form, your employer listed above must make health care contributions for you *unless and until* you sign a new waiver form.

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

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

EMPLOYEE VOLUNTARY WAIVER

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

Employer Providing Health Care Services	
Type of Health Care Benefit and Administrator (Insurance Provider or Benefits Administrator)	
Employer Address:	
Contact Person:	
Tel: Email:	

I certify that I am receiving health care services from the above named employer through my (check the appropriate option):

[ ] Other job
[ ] Parent
[ ] Spouse or partner

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. **If you want your employer to provide you with access to health care services as required by law, do not sign this form.**

Employee Signature:

Employee Name: Today's Date:

EMPLOYEE REVOCATION OF VOLUNTARY WAIVER FORM

Complete this section ONLY if you wish to revoke 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:

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Employer and employees should keep a copy of this form.