



City of Torrance

2025 Declination of Health Insurance Coverage

This form is required if you are opting out of the City of Torrance health insurance plan for the 2024 plan year.

Under the Affordable Care Act (ACA), the City of Torrance is required to offer affordable minimum essential coverage to all full-time employees and those employees who are defined as full-time equivalent by ACA. By opting out of the City's group health insurance plan, I agree to the following **(initial each box after reviewing)**:

Initials

I understand that this election is final once submitted, and I can only re-enroll myself and my dependents if I experience one of the following situations:

1. I experience a qualifying life event, such as: marriage, birth, adoption, or loss of coverage due to divorce, change in employment status, or loss of eligibility for coverage. Under these circumstances, I must notify the Human Resources Benefits Unit within 30 days of the event and provide any requested documentation; or
2. During the annual Open Enrollment period.

Initials

I understand that I must show proof (insurance card, benefits summary from health provider, or other verifiable proof as determined by Human Resources) to Human Resources that I have alternative minimum essential coverage (other than coverage in the individual market and other than individual coverage through Covered California). I acknowledge that my coverage is not individual coverage from Covered California.

Name of plan holder who I receive insurance under: _____

Relationship: _____

Insurance Company: _____

Initials

I certify that all eligible dependents listed on my income tax return have minimum essential coverage other than coverage in the individual market and other than individual coverage through Covered California.

Once signed, employees shall submit this form and a copy of proof of health coverage to Human Resources.

I have read and understand the above conditions and procedures for opting out of the City's group health insurance plan. I certify that all information contained on this form is accurate under penalty of perjury.

Employee ID: _____

Employee Name: _____

Date Signed: _____

Employee Signature: _____

For HR Staff use only

Bargaining Unit: _____

Date Form Received: _____

Entered in EmPath

Proof of Insurance Received: _____

Received By (staff initials): _____

Copy for ACA Tracking: _____