



**Lisette Estrella-Henderson, Superintendent of Schools**  
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## Waiver of Medical Coverage for 2025

I DECLINE ENROLLMENT into the CalPERS Health Program for myself and my dependents. I understand that the lowest cost employee only plan in Solano County for 2025 is \$914.27 per month prior to the employer contribution.

I understand that if I choose to enroll later, I must wait until the next Open Enrollment (OE) period before enrolling or have a qualifying loss of coverage. If I or my dependents involuntarily lose other health insurance coverage, I may request enrollment into the program within 60 days from the date of lost coverage. If I do not request enrollment within 60 days, I must wait until the next OE period before I can enroll. The effective date of coverage will be the first of the month following the receipt of the enrollment form or the OE effective date.

Employee Name: \_\_\_\_\_

Employee ID Number: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please return this form to Payroll and Benefits if you are choosing not to participate in the CalPERS Health Program for 2025, this is an annual request. If you are currently enrolled in a plan or enrolling in a plan during open enrollment, you do not need to complete this form.** The form can be returned via courier, regular mail, or by email to [scoepayroll@solanocoe.net](mailto:scoepayroll@solanocoe.net). If you have any questions, please send an email to [scoepayroll@solanocoe.net](mailto:scoepayroll@solanocoe.net) or call (707) 399-4421 or (707) 399-4424.