



PROOF OF OTHER COVERAGE STATEMENT

If you elected to **WAIVE MEDICAL COVERAGE**, you must complete this form and sign the statement below.

Name: _____
Last First MI

I have current medical coverage under another plan as indicated below:

Source of other coverage (i.e. employer name)

Insurance company or the organization providing coverage

Please check the box below:

I certify that the above information is true and correct as of the date indicated below.

Signature

Date

Return the completed form to Human Resources.
HR@losgatosca.gov