



Broward County Human Resources Division
 Employee Benefit Services Section
 115 S Andrews Avenue, Ste. 514, Fort Lauderdale FL 33301
 Office: 954-357-6700 | Secured Facsimile: 954-728-2777 Email:
 Benefits@broward.org | Website: Broward.org/benefits

PROOF OF OTHER GROUP HEALTH INSURANCE – 2021

As a benefit-eligible employee, you waived enrollment in County-offered health insurance coverage. To receive the Waiver Credit provided by the County (full-time employees: \$100.00 per pay check, PT 20 employees: \$50.00 per paycheck,) you must show proof of other 2021 group health insurance, Medicare Part A & B enrollment, Medicaid, Tricare Coverage or Veterans coverage. The Waiver Credit is not provided for enrollment in the Health Care Exchange, a Medi-Share program or Individual Coverage.

Examples of proof of other 2021 group health coverage are:

- A copy of your insurance card (must show a date proving coverage in 2021)
- Insurance coverage letter from your group insurance carrier specifying coverage in 2021
- A letter from your spouse/domestic partner’s employer that states you are enrolled for the 2021 Benefit year
- An open enrollment confirmation statement for group health insurance specifying elections for 2021

Medicare Part A & B, Tricare and Veterans – if not already provided to employee Benefit Services:

- Copy of Medicare Card showing Part A & B
- Tricare members can provide a copy of their uniformed service ID card
- Veterans can provide an ID card or letter or other documentation from Veterans Services

IF YOU DO NOT PROVIDE ELIGIBLE PROOF OF OTHER COVERAGE, YOU WILL NOT RECEIVE THE WAIVER CREDIT

Employee _____ Employee ID# _____

Insured under your Parent Spouse/Domestic Partner Self Other _____

Insured’s Name _____

Is the person above a Broward County Employee? Yes No

Name of Group Plan Sponsor _____ Insurance Company _____

Coverage Effective Date _____ Coverage Expiration Date _____

AUTHORIZATION

By signing this document, you agree to allow your group health insurance plan sponsor to provide your name and detailed information about your health insurance benefit plan to Broward County, Employee Benefit Services, for the purpose of determining eligibility for the Waiver Credit. If you would like to revoke this authorization at any time, written notice must be provided to Broward County Employee Benefit Services. However, any actions taken by Broward County Employee Benefit Services in reliance on your authorization before you revoked it will not be affected by therevocation.

EMPLOYEE SIGNATURE: _____

INSURER’S SIGNATURE (IF APPLICABLE): _____

EMPLOYEE BENEFITS USE ONLY		
COMMENTS _____		
KEYED BY	AUDITED BY	EFFECTIVE DATE

RETURN INSTRUCTIONS: Please send proof of coverage directly to:
 Broward County Employee Benefit Services | Fax: 954-728-2777 | Email: Benefits@broward.org