CITY OF GLENDALE, CALIFORNIA
Human Resources
Civil Service Commission

613 E. Broadway, Suite 100
Glendale, CA 91206-4308
Tel. (818) 548-2110
glendaleca.gov

City of Glendale Benefit Waiver Form

Name: _____

☐ New Hire ☐ Active Employee ☐ Retiree

Employee ID: _____

Social Security (last 4): _____

Date of Birth: _____

Phone Number: _____

Email Address: _____

Waiver of Coverage:

I have been offered the opportunity of participating in the City of Glendale's health insurance program and have chosen to waive the following plans:

☐ Medical (*Only ACA eligible benefit available)
☐ Dental
☐ Vision
☐ Supplemental or Retiree Life (if applicable)

My reason is:

☐ Cost
☐ Other Group Coverage - please specify coverage: _____
_____
☐ Other: _____

Additional Notes (if any): _____

Please discontinue my coverage with the following effective date: _____
(Note: Effective date must be the 1st of the designated month (cannot be retroactive).

_____ _____
Signature Date

Form can be scanned and emailed to Benefits@glendaleca.gov or faxed to Benefits at (818) 243-8428.