



City of Petaluma  
**HUMAN RESOURCES**  
**Cash In-Lieu Health and Dental Benefits**

*To be completed by Employee*

**I. Employee Information**

Employee Name \_\_\_\_\_ Position \_\_\_\_\_ Employee Number \_\_\_\_\_

**Election of Cash in Lieu (select below):** \_\_\_\_\_ **Effective Date** \_\_\_\_\_

Employee Benefit	Level of Coverage (single, 2 party, Family)	Current Rate	Cash In-Lieu Amount per month
Health Coverage			
Dental Coverage			
Total Benefit Amount:			

- I elect to make the following declination of benefits above and attached is proof of my other health and/or dental coverage. This benefit is an elective and is subject to the terms and conditions under my MOU/Compensation Plan.
- I authorize the City of Petaluma to cancel my benefit as designated above.
- This election will remain in effect and automatically renew each calendar year.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

**Cancellation of Cash In-Lieu Benefit:** \_\_\_\_\_ **Effective Date** \_\_\_\_\_

- I elect to cancel the cash in-lieu benefit and have provided the appropriate forms indicating loss of health and dental coverage to the Human Resources office.
- I have filled out the health and/or dental enrollment forms.
- I understand that this cancellation will reduce my gross earnings at the next available pay period.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

*To be completed by Human Resources*

**II. Human Resources Approval**

I have reviewed this employee request and certify that the paperwork submitted meets the cash in-lieu benefit.

Human Resources \_\_\_\_\_ Printed Name \_\_\_\_\_ Date \_\_\_\_\_