☐ **PIH Health Downey Hospital**

☐ **PIH Health Good Samaritan Hospital**

☐ **PIH Health Physicians**

☐ **PIH Health Whittier Hospital**

2026 Employee / Spousal CashBack Form

CashBack's are available to employees or their spouses who have access to other medical coverage outside of PIH Health. **If you are covered as a dependent under a PIH Health Medical Plan, Medi-Cal, Medicare, or other government sponsored programs, you do not qualify for CashBack.** You must enroll in this benefit option annually during open enrollment. Failure to do so forfeits this benefit for the entire benefits plan year.

All forms and proof of other credible insurance must be submitted to Human Resources or emailed to Employee.Benefits@PIHHealth.org by your enrollment deadline. No exceptions.

You may only enroll in ONE of the below options:

☐ **Employee CashBack:** Employees who choose to waive out of the PIH Health Medical Plans receive $100.00 per month ($46.15 per paycheck) from PIH Health.

OR

☐ **Spousal CashBack:** Employees who choose to waive their spouses only out of the PIH Health Medical Plans will receive $100.00 per month ($46.15 per pay check) from PIH Health.

To elect Employee CashBack, answer the question below and sign:

Are you enrolled in other employer-sponsored medical coverage and are, therefore, choosing to waive out of the PIH Health Medical Plans and electing the Employee CashBack?

Yes ___ No ___

By electing Employee CashBack, you are confirming you have insurance coverage outside of the PIH Health Medical Plans. Per California state law, you must have medical coverage. Please be aware if you do not have coverage, you will be penalized by Internal Revenue Service (IRS).

By signing below, I hereby certify and warrant to PIH Health that all information on this form is true, correct, and current as of the date signed. I understand that if I knowingly submit false information, I may be subject to disciplinary action, up to and including termination of employment and appropriate legal recourse. Furthermore, my signature authorizes PIH Health to verify any and all documents provided and to contact any institution or organization to verify the facts as stated herein.

Employee Signature: _____ Employee Number: _____

Employee Name:_____ Date: _____

Please also attach proof of other credible coverage, such as a copy of your insurance card.

To elect Spousal CashBack, please answer the question below and sign:

If you elect a PIH Health Medical Plan and would like to waive your spouse from enrolling in the plan to receive the Spousal CashBack, please complete the below:

Spouse Name *(Last Name, First Name)*: _____

1) Is your spouse currently employed or self-employed? Yes ___ No ___

   If you checked **Yes**, complete question number 2.

   If you checked **No**, your spouse will not qualify for Spousal CashBack.

2) Is your spouse covered as a dependent under a PIH Health Medical Plan? Medi-cal, Medicare or any other government sponsored programs? Yes ___ No ___

   If **Yes**, your spouse will not qualify for Spousal CashBack.

   If **No**, complete question number 3

3) Will your spouse be enrolled in other employer sponsored medical coverage outside of PIH Health effective January 1, 2026? Yes ___ No ___

   If **Yes,** your spouse if eligible for the $100 / month Spousal CashBack.

By electing Spousal CashBack, you are confirming your spouse has insurance coverage outside of the PIH Health offered medical plans. Per California state law, you must have medical coverage. Please be aware if you do not have coverage you will be penalized by the IRS.

By signing below, I hereby certify and warrant to PIH Health that all information on this form is true, correct, and current as of the date signed. I further understand if I knowingly submit false information I may be subject to disciplinary action, up to and including termination of employment and appropriate legal recourse. Furthermore, my signature authorizes PIH Health to verify any and all documents provided and to contact any institution or organization to verify the facts as stated herein.

Employee Signature: _____ Employee Number: _____

Employee Name:_____Date: _____

Please also attach proof of other credible coverage such as a copy of your insurance card.