CITYWIDE HOTEL WORKER MINIMUM WAGE BENEFIT WAIVER

EXEMPTION THAT REQUIRES OFFICE OF WAGE STANDARDS (OWS) APPROVAL

Beginning on July 1, 2026, the Citywide Hotel Worker Minimum Wage Ordinance (CHMWO) requires Hotel Employers to provide health benefits to Hotel Workers.(See Los Angeles Municipal Code (LAMC) Sections 186.01D & 186.04) The CHMWO, however, permits Hotel Workers to waive the required health care benefits, if they are eligible for benefits under Medicare, a health plan through the US Department of Veteran Affairs, or a health plan in which the Hotel Worker's spouse, domestic partner, or parent is a participant or subscriber. Note: Coverage through Medi-Cal does not qualify. A Hotel Worker who receives this waiver will instead be entitled to the minimum hourly wage set forth in Section 186.02.A.1, and an additional monthly payment pursuant to either 186.10.C.1 or 186.10.C.2.

Any Hotel Worker **who wishes to waive these benefits should submit this form,** along with supporting documents to: **wagesla@lacity.org; or Office of Wage Standards, 1149 S. Broadway. Suite 300 Los Angeles, CA 90015.**

INACCURATE OR INCOMPLETE SUBMISSIONS WILL BE RETURNED.

SECTION I: HOTEL WORKER INFORMATION

1. Employee Name: _____ Phone Number: _____
2. Employee Email Address: _____
3. Employee Address: _____
4. Employer Name: _____
5. Employer Address: _____

SECTION II: BENEFIT INFORMATION

By submitting this waiver application, I understand the following (check off all boxes):

☐ I am seeking to voluntarily waive health benefits from my Employer (i.e. health, dental, vision, mental health, and disability income).

☐ Should I need health benefits from my Employer after having voluntarily waived them, I will only be able to elect benefits during annual Open Enrollment or if I experience a qualifying life changing event.

☐ Even if this waiver is approved, my Employer is not required to waive the company's health benefits plan for me.

☐ If my waiver is in effect, I am entitled to only the minimum hourly wage in LAMC Section 186.02.A.1 and an additional monthly payment of either $100 (for a full-time employee) or $50 (as a part-time employee).

☐ I am representing that I am eligible for benefits under another health plan in which my spouse, domestic partner or parent is a participant or subscriber and/or I receive health benefits through a Federal Medicare/ Department of Veteran Affairs Insurance Program.

SECTION III: DOCUMENTATION

1) Please indicate the health plan under which you are covered:

☐ My spouse (S) ☐ My domestic partner (DP) ☐ My parent (P) ☐Medicare ☐ Dept. Of Veteran Affairs

2) Please provide a copy of your insurance card. In addition, please provide one of the following documents to prove you are covered under a spouse, domestic partner, parent's health plan OR through Medicare/ Dept. of Veteran Affairs:

☐Statement from S/DP/P's insurer ☐Statement from S/DP/P's employer ☐Tax Form 1095-B

☐Evidence of Coverage Letter from Medicare/ Dept. Veteran Affairs ☐Other _____

SECTION IV: SIGNATURE

By signing this form, you (the Hotel Worker) certify under penalty of perjury under the laws of the State of California that the information submitted in support of this application is true and correct to the best of your knowledge.

_____
PRINT NAME

_____ _____
SIGNATURE DATE

ANY APPROVAL OF THIS APPLICATION EXEMPTS ONLY THE LISTED EMPLOYEE FROM THE HEALTH BENEFITS PROVISIONS OF THE CITYWIDE HOTEL WORKER MINIMUM WAGE ORDINANCE.

OFFICE OF WAGE STANDARDS USE ONLY

Approved / Not Approved – Reason: _____

By Analyst: _____ **Date:** _____