# Declination of Coverage Form

CERTIFICATION OF OTHER COVERAGE

Western Health Advantage

I understand that I have been offered coverage through my employer in Western Health Advantage (WHA). I voluntarily choose not to enroll in WHA through my employer at this time. I understand my next opportunity to enroll myself or my eligible dependents will be during my employer's open enrollment period, which may be up to 12 months from the date I sign this form. WHA's Evidence of Coverage and Disclosure Form informs me and my employer of special enrollment rights due to: (1) to the birth or adoption of a dependent, and (2) to loss of other coverage.

Group Name_____ Group #_____

Employee First Name_____ Last Name_____

**I am declining coverage for the reason checked below:**

❑ **For Myself**

- ❑ I am covered as a dependent through another employer's health plan
- ❑ I am covered under COBRA continuation coverage, Access for Infants and Mothers (AIM) Health Families, or Medi-Cal
- ❑ Other_____

❑ **For My Spouse/Domestic Partner Only**

❑ **For Children Only**

❑ **For My Spouse/Domestic Partner and Children**

- ❑ Each dependent not enrolled is covered as an employee or dependent under another employer's health benefit plan
- ❑ Each dependent not enrolled is covered under COBRA continuation coverage, Access for Infants and Mothers (AIM) Health Families, or Medi-Cal
- ❑ Other_____

Employee Signature_____ Date_____