Enrollment Declination Form

Please complete this form **ONLY** if you **do not** want coverage for yourself and/or your dependents.

Section A: Personal Information (To be completed by Employee)			
Name of Company:		Employer Phone Number:	Employee Social Security Number:
Employee Last Name:	Employee First Name:	Middle Initial:	Date of Birth (mm/dd/yyyy): / /

Section B: Type of Declination (Check all that apply and include names of dependents which is required)			
I am declining coverage for:	Medical	Dental	Vision
Myself	❑	❑	❑
Spouse/Domestic Partner	❑	❑	❑
Child(ren)	❑	❑	❑
Name:	❑	❑	❑
Name:	❑	❑	❑
Name:	❑	❑	❑

Section C: Reason for Declining Coverage (Must be filled out completely)		
❑ Other Group Coverage through a Spouse/Domestic Partner Medical Carrier Name: Dental Carrier Name: Vision Carrier Name:	Attach proof of coverage Group # Group # Group #	Company Sponsor
❑ Individual Coverage (Choose one): ❑ Medicare ❑ Medi-Cal ❑ Individual Policy ______________________________ ❑ Other Reason:		

Section D: Special Enrollment Rights

In certain circumstances, you and your eligible dependents may have rights to enroll outside the Open Enrollment period: To take advantage of special enrollment rights, you must request enrollment with the Plan Administrator (via your Employer) within 30 days of the event that triggers the special enrollment. Special enrollment rights may be triggered by any of the following events:

- If you or any of your dependents declined enrollment under this Plan because of other health insurance coverage, other than COBRA coverage, but afterwards lost eligibility for that coverage for any of the following reasons other than the failure to pay timely premiums or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the other plan);
- Loss of eligible coverage as result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of the employee, termination of employment, and reduction in the number of hours of employment;
- In the case of coverage through an individual HMO, a loss of eligibility for coverage under your individual HMO because you no longer reside, live, or work in the HMO service area and no other benefit package is available to you;
- The other plan ceases to offer any benefits to the class of similarly situated individuals that includes you or your dependent (e.g., your dependent is a part-time employee with Employer A and Employer A discontinues coverage for part-time employees);
- If you are covered under another plan for which an employer makes a contribution towards your premium and that contribution is terminated (such contributions must be completely terminated; a reduction in the value of the benefit or an increase in cost to the participant does not trigger a special enrollment right); or
- You exhaust COBRA coverage; ·or
- If you acquire a new dependent(s) as a result of marriage or domestic partnership, birth, adoption, or placement for adoption, you may be able to add the new spouse or domestic partner or child(ren), or enroll yourself and your dependents.
- If you are covered by a medical plan or HMO offered under the plan and you enroll yourself and/or a new dependent(s) in accordance with the Plan's special enrollment procedures, you have the right to enroll in any other medical plan or HMO option for which you and your dependents are eligible.

Section E: Your Legal Acknowledgment

By signing, I understand that by failing to elect coverage now, I will not be able to enroll until the next Open Enrollment period or a Qualifying Event occurs as stated above. This declination provision will not apply if a Court orders coverage of a spouse or child and the request for enrollment follows the Special Enrollment Rights guidelines as stated above.

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Employee Signature to Decline Coverage   Date

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Print Name