

INSURANCE COVERAGE DECLINATION FORM

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

Please note that Chiropractic and Vision coverage, if offered by your Employer, cannot be waived when enrolling for Medical coverage.

SECTION A: PERSONAL INFORMATION (to be completed by Employee)

Name of Company		Employer Phone Number ()	
Employee Last Name	First Name		Middle Initial
Date of Hire		Employee Social Security Number	

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	Chiro / Acup
<input type="checkbox"/> Myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Spouse or <input type="checkbox"/> Domestic Partner Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Child(ren) Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION C: REASON FOR DECLINING COVERAGE (must be filled out completely)

<input type="checkbox"/> Other Group Coverage through a Spouse/Domestic Partner: Medical Carrier Name: _____ Dental Carrier Name: _____ Vision Carrier Name: _____ Chiropractic Carrier Name: _____	(list and attach proof of coverage) Group #: _____ Group #: _____ Group #: _____ Group #: _____	Company Sponsor _____ _____ _____ _____
<input type="checkbox"/> Individual Coverage: (please choose one) <input type="checkbox"/> Medicare <input type="checkbox"/> Medi-Cal <input type="checkbox"/> Individual Policy _____		
<input type="checkbox"/> Other Reasons: _____		

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 Contract Administrator (via your Employer) within 30 days of the event triggering 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 eligibility for 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's service area;
 - In the case of coverage through a group HMO, a loss of eligibility for coverage under the group HMO because you no longer reside, live or work in the HMO's service area and no other benefit package is available to you;
 - If you incur a claim under the other plan that would meet or exceed a lifetime limit on all benefits under the other plan; or
 - 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 ACKNOWLEDGEMENT 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.

Employee Signature to Decline Coverage X	Date _____
Print Name _____	