DECLINATION FORM

I hereby decline the following coverage:

- ☐ Medical
- ☐ Dental
- ☐ Vision

I hereby decline the above referenced coverage for the following persons:

Self:	SSN #:

Check reasons:

- ☐ I am covered under another health plan
- ☐ I am not covered under another health plan, but do not choose to enroll at this time

Spouse:	SSN #:

Check reasons:

- ☐ I am covered under another health plan
- ☐ I am not covered under another health plan, but do not choose to enroll at this time

Child:	SSN #:

Check reasons:

- ☐ I am covered under another health plan
- ☐ I am not covered under another health plan, but do not choose to enroll at this time

[Fill out a statement for each individual eligible for coverage, but for whom you are declining coverage. Use the back of this form if necessary.]

I, the undersigned, understand that by declining coverage at this time, if I choose to apply for enrollment at a later date, I may be excluded from coverage for a period of up to 12 months. In addition, once enrolled, I understand that my coverage may be subject to a six month exclusion for pre-existing conditions.

"Note: If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

_____ _____

Employee Name (print or type) Employee Signature Date

_____ _____

Employer Representative Name & Title Date

Group Number

Representative Signature

Child:	SSN #:

Check reasons:

- ☐ I am covered under another health plan
- ☐ I am not covered under another health plan, but do not choose to enroll at this time

Child:	SSN #:

Check reasons:

- ☐ I am covered under another health plan
- ☐ I am not covered under another health plan, but do not choose to enroll at this time

Child:	SSN #:

Check reasons:

- ☐ I am covered under another health plan
- ☐ I am not covered under another health plan, but do not choose to enroll at this time

Child:	SSN #:

Check reasons:

- ☐ I am covered under another health plan
- ☐ I am not covered under another health plan, but do not choose to enroll at this time

Child:	SSN #:

Check reasons:

- ☐ I am covered under another health plan
- ☐ I am not covered under another health plan, but do not choose to enroll at this time

Child:	SSN #:

Check reasons:

- ☐ I am covered under another health plan
- ☐ I am not covered under another health plan, but do not choose to enroll at this time