

REFUSAL OF HEALTH COVERAGE

PLEASE PRINT

Company Name		Group No.
Employee Name (Last, First, MI)		SSN
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner		Occupation / Job Title
<p>I am declining coverage for:</p> <p><input type="checkbox"/> Myself and all dependents</p> <p><input type="checkbox"/> Spouse only</p> <p><input type="checkbox"/> Child(ren) only</p> <p><input type="checkbox"/> Both spouse & child(ren)</p>	<p>Reason for declining coverage:</p> <p><input type="checkbox"/> Spouse's group health coverage. Carrier Name & ID# _____</p> <p><input type="checkbox"/> Individual health coverage. Carrier Name & ID# _____</p> <p><input type="checkbox"/> Medicare</p> <p><input type="checkbox"/> Other health coverage. Carrier Name & ID# _____</p> <p><input type="checkbox"/> Other reason _____</p>	
<p>I acknowledge that the coverage available to me has been explained to me by my employer, and I know that I have every right to enroll in this coverage and I have decided not to enroll myself and/or my dependent(s), if any. I now decline to enroll myself, and/or my dependent(s) in my employer's Blue Shield health plan. I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to decline coverage.</p> <p>If I acquire a new dependent as the result of marriage, birth, adoption or placement for adoption, I acknowledge that I, and any dependents I may have, may request enrollment in my employer's health plan by applying for that coverage within 31 days of the marriage, birth, adoption, or placement for adoption.</p> <p>If I and/or my dependent(s) has/have other health coverage at this time, and I have so indicated the other coverage(s) where requested above, I acknowledge that if I or my dependent(s) involuntarily lose the other coverage(s) I may request enrollment in my employer's health plan within 31 days of the involuntary loss of the other health coverage.</p> <p>If I do not enroll eligible dependents within 31 days of the qualifying events described above, I understand that I may not enroll any dependents until the end of my employer's next open enrollment period, or after 12 months, whichever is earlier.</p>		
<p>Signature of Employee X _____ Date _____</p>		

**EMPLOYERS MUST RETAIN A COPY OF ANY SIGNED
REFUSAL OF COVERAGE FOR THEIR RECORDS**