Refusal of Coverage form

Complete this form if you, your spouse, domestic partner, or child dependent(s) are refusing this group health, dental, vision, and/or life insurance coverage offered through the employer. (The employer must retain a copy of this form to provide to Blue Shield upon request.) Please type or print. Use black ink. ***Note: The employee's Social Security number is required for all eligible employees and dependents.**

Employee name	**Social Security number**	**Date of birth**
Employer (Group) name	**Hire date** _____	**State of residence**
Marital status Married ☐ Yes ☐ No Domestic partnership ☐ Yes ☐ No	Job title	

Is the employee a full-time employee, working at least 30 hours per week for this employer? ☐ Yes ☐ No **Or**
Is the employee a part-time employee, working at least 20 hours per week for this employer? ☐ Yes ☐ No

Declining coverage for:

I decline health plan coverage for:
- ☐ Myself and all dependents.
- ☐ My spouse/domestic partner only
- ☐ My children only
- ☐ My spouse/domestic partner and children only
- ☐ The following dependents only:

_____

If dental plan offered, I decline dental plan coverage for:
- ☐ Myself and all dependents.
- ☐ My spouse/domestic partner
- ☐ My children
- ☐ My spouse/domestic partner and children
- ☐ The following dependents only:

_____

If vision plan offered, I decline vision plan coverage for:
- ☐ Myself and all dependents
- ☐ My spouse/domestic partner
- ☐ My children
- ☐ My spouse/domestic partner and children
- ☐ The following dependents only:

_____

If life insurance plan offered, I decline life plan coverage for:
- ☐ Myself

Reason for declining coverage

OTHER EMPLOYER HEALTH COVERAGE
- ☐ Enrolling as a dependent or an employee on this group health plan
- ☐ Covered by this employer's other health plan (through another carrier)
- ☐ Covered by another employer's health plan (e.g., through your spouse/domestic partner)
  Carrier name _____
  ID number _____
- ☐ Covered by TRICARE

OTHER NON-EMPLOYER HEALTH COVERAGE
- ☐ Covered by an individual health plan.
  Carrier name _____
  ID number _____
- ☐ Covered California or other State Health Exchange
- ☐ Medicare, Medi-Cal, Healthy Families Program
- ☐ Other _____

OTHER DENTAL COVERAGE
- ☐ Enrolling as a dependent on this group dental plan
- ☐ Covered by another employer's dental plan (e.g., through your spouse/domestic partner)
  Carrier name _____
  ID number _____
- ☐ Other _____

OTHER VISION COVERAGE
- ☐ Enrolling as a dependent on this group vision plan
- ☐ Covered by another employer's vision plan (e.g., through your spouse/domestic partner)
  Carrier name _____
  ID number _____
- ☐ Other _____

OTHER LIFE INSURANCE COVERAGE
- ☐ Covered by another employer's life insurance coverage (e.g., through your spouse/domestic partner)
  Carrier name _____
  ID number _____
- ☐ Other _____

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, my spouse/domestic partner, and/or my child dependent(s) in my employer's group 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.

If I am declining enrollment for myself or my dependents because of other health coverage or because the employer stops contributing toward this coverage, I acknowledge that I may be able to enroll myself and my dependents in this plan if I request enrollment within 60 days after my or my dependents' other coverage ends or after the employer stops contributing toward the other coverage.

In addition, if I acquire a new dependent as the result of marriage/domestic partnership, birth, adoption or placement for adoption, I acknowledge that I, and my dependents, may request enrollment in my employer's health plan by applying for that coverage within 60 days of the marriage/domestic partnership, birth, adoption, or placement for adoption. I also acknowledge that if I, or my dependents, become eligible for the Healthy Families or the Medi-Cal Premium Assistance programs, I or my dependents may request enrollment in my employer's health plan by applying for coverage within 60 days of the notice of eligibility for these premium assistance programs.

If I have indicated above that the reason for declining coverage for myself or my dependent(s) is coverage under another employer health benefit plan, I acknowledge that if I or my dependent(s) involuntarily lose coverage under the other employer health benefit plan, I must request enrollment for myself and/or my dependent(s) in my employer health benefit plan within 60 days. Otherwise, I understand I may not enroll myself and/or my dependents in my employer's health plan until the earlier of the end of my employer's next open enrollment period or 12 months.

Signature of employee _____ **Date** _____

Print name _____