Declination of Coverage Form

CERTIFICATION OF OTHER COVERAGE



I understand that I have been offered coverage through my employer in Western Health Advantage (WHA). I voluntarily choose not to enroll in WHA through my employer at this time. I understand my next opportunity to enroll myself or my eligible dependents will be during my employer's open enrollment period, which may be up to 12 months from the date I sign this form. WHA's Evidence of Coverage and Disclosure Form informs me and my employer of special enrollment rights due to: (1) to the birth or adoption of a dependent, and (2) to loss of other coverage.

Group Name	Group #
Employee First Name	Last Name
I am declining coverage for the reason checked b	elow:
☐ For Myself	
☐ I am covered as a dependent through anoth	er employer's health plan
☐ I am covered under COBRA continuation cov Medi-Cal	verage, Access for Infants and Mothers (AIM) Health Families, or
☐ Other	
☐ For My Spouse/Domestic Partner Only	
☐ For Children Only	
☐ For My Spouse/Domestic Partner and Childre	en
☐ Each dependent not enrolled is covered as a plan	an employee or dependent under another employer's health benefit
☐ Each dependent not enrolled is covered und (AIM) Health Families, or Medi-Cal	der COBRA continuation coverage, Access for Infants and Mothers
☐ Other	
Employee Cignature	Data