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.**

Employee name	**Social Security number**	**Date of birth**
Employer (Group) name		**State of residence**
	Hire date	
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 only
- ☐ My children only
- ☐ My spouse/domestic partner and children only
- ☐ The following dependents only:

_____

If vision plan offered, I decline vision 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 life insurance plan offered, I decline life plan coverage for:

- ☐ Myself

Reason employee is declining health coverage

Other employer health coverage

- ☐ Enrolling as a dependent of 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, including COBRA or Cal-COBRA coverage, through your spouse/domestic partner, parent, or previous employer

Other non-employer health coverage

- ☐ Covered by an individual/family health plan
- ☐ Covered by Government program, including Medicare, Medi-Cal, Healthy Families Program, TRICARE, Indian Health Service, Tribal and Urban Indian Health Program, and Veterans Health Administration (VA)

☐ **Other reasons**

Reason employee is declining dental coverage

Other dental coverage

- ☐ Enrolling as a dependent of an employee on this group dental plan
- ☐ Covered by another employer's dental plan, including COBRA or Cal-COBRA dental coverage, through your spouse/domestic partner, parent, or previous employer
- ☐ Covered by an individual/family dental plan

☐ **Other reasons**

Reason employee is declining vision coverage

Other vision coverage

- ☐ Enrolling as a dependent of an employee on this group vision plan
- ☐ Covered by another employer's vision plan, including COBRA or Cal-COBRA vision coverage, through your spouse/domestic partner, parent, or previous employer
- ☐ Covered by an individual/family vision plan

☐ **Other reasons**

Reason employee is declining life insurance coverage

Other life insurance coverage

- ☐ Covered by another employer's life insurance coverage through your spouse/domestic partner or parent

Other reasons

- ☐ Cost of coverage
- ☐ Do not need or do not want coverage

I acknowledge that the coverage available to me has been explained to me by my employer. 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 end of my employer's next open enrollment period or 12 months (whichever is earlier).

For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Signature of employee _____ **Date** _____