Declination of Coverage

TO BE COMPLETED BY GROUP ADMINISTRATOR	PLAN YEAR	GROUP

LAST NAME	FIRST NAME
SOCIAL SECURITY NUMBER	

_____ (INITIAL) I am rejecting Employee and/or Dependent Coverage. I certify that I have been given the opportunity to participate in the group health insurance plan offered by my employer and have declined to participate. I understand that the individual mandate from Health Care Reform requires that almost all individuals must obtain minimum essential health coverage or potentially pay a tax (Please visit coveredca.com for more information). I have declined to participate for the following reason (check one):

□ An individual plan

□ My spouse's group coverage

□ COBRA or State Continuation

□ A government plan

□ I and/or my dependents are currently not covered by any other health benefit plan

□ Other (explain): _____

I understand my next opportunity to enroll myself or my eligible dependents will be during the next open enrollment period, except under the conditions listed below:

Notice of Special Enrollment

If you are declining coverage for you and your dependent(s) because you and/or your dependents have coverage elsewhere and you or your dependents subsequently lose coverage, you may enroll yourself and your dependents immediately, provided you notify the district within 30 calendar days of loss of coverage. In addition, if you have a new dependent as a result of marriage, birth, adoption, placement for adoption, or placed in your home as a result of court ordered custody or guardianship, you may enroll yourself and your dependents, provided you request enrollment within 30 calendar days of this event.

If you decline coverage and subsequently become a full-time employee, you must enroll in a plan the first of the month following the date of this event. If the number of work hours increases, you may choose to enroll the first of the month following the date of that occurrence.

Signature of Employee_____ Date_____