DECLINATION OF COVERAGE

Name of Employee: _____

Name of Employer: _____

Please check appropriate boxes

I hereby acknowledge I have been offered group coverage under my employer's health plans and I have declined coverage for:

☐ Myself ☐ Myself and my eligible Family Members ☐ My Eligible Family Members

Name of Family Members declining coverage: _____

_____

Coverage has been declined because I and/or my family members:

1. ☐ Have other group health coverage through my spouse's employer

   ☐ Medical Coverage ☐ Dental Coverage

2. ☐ Have individual medical/dental coverage
3. ☐ Have Medicare coverage
4. ☐ Have other coverage (explain): _____
5. ☐ I do not have other medical/dental coverage

If you checked number 2, 3, or 4, please complete the Coverage Information section below.

COVERAGE INFORMATION

Policy Number	ID Number
Name of Insurance Company	Name of Employer

If I (and my eligible dependent(s)) choose to enroll at a later date, I agree to see my employer for enrollment instructions. I understand it may be up to one year before I am again eligible for coverage.

Signature_____ Date: _____

Employer: Keep in employee's file