REFUSAL OF PERSONAL COVERAGE

(Complete if you, your spouse or dependent(s)
are refusing your employer's Blue Shield health and/or dental plan coverage)

PLEASE PRINT

EMPLOYEE NAME	SOCIAL SECURITY #	
EMPLOYER (GROUP) NAME	HIRE DATE	GROUP NUMBER
MARITAL STATUS MARRIED ❑ YES ❑ NO	JOB TITLE	

Are you a full-time employee, working at least 30 hours per week for this employer? ❑ **Yes** ❑ **No** If no, please explain? ____________

____

DECLINING COVERAGE FOR:

❑ I decline health plan coverage for myself, my spouse and all dependents.

❑ I decline health plan coverage for my:

- ❑ Spouse Only
- ❑ Children Only
- ❑ Spouse and Children
- ❑ Following Dependents Only:

____

____

❑ If dental offered, I decline dental coverage for myself, my spouse and all dependents.

REASON FOR DECLINING COVERAGE

❑ Covered by another employer's health plan (e.g., through your spouse).
Carrier Name and ID Number ____________

❑ Covered by an Individual Health Plan.
Carrier Name ____________

❑ Medicare

❑ Covered by Champus or Champva.

❑ Other – e.g., any other individual or employer health coverage.
(explain) ____________

❑ No other employer health coverage.

❑ Covered by another dental plan.
Carrier Name and ID Number ____________

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 and/or my dependent(s) in my employer Blue Shield 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 acquire a new dependent as the result of marriage, birth, adoption or placement for adoption, I acknowledge that I, and any dependents I may have, may request enrollment in my employer's health plan by applying for that coverage within 31 days of the marriage, birth, adoption, or placement for adoption.

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 31 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 X ____________ **Date** X ____________

EMPLOYERS MUST RETAIN A COPY OF ANY SIGNED
PERSONAL REFUSAL OF COVERAGE FOR THEIR RECORDS