blue of california

REFUSAL OF PERSONAL COVERAGE
Blue Shield of California and
Blue Shield of California Life & Health Insurance Company

(Complete if you, your spouse, domestic partner, or dependent(s) are refusing your employer's Blue Shield of California/Blue Shield Life health and/or dental plan coverage.)

Please type or print clearly. Use black ink.

Employee first name | MI | Employee last name | Social Security number

Employer (group) name | Customer number | Hire date (mm/dd/yyyy) / /

Declining coverage for:

- ○ I decline health plan coverage for myself, my spouse/domestic partner and all dependents.
- ○ I decline health plan coverage for:
  - ○ My spouse/domestic partner only
  - ○ My children only
  - ○ My spouse/domestic partner and children
  - ○ The following dependents only:
- ○ If dental offered, I decline dental coverage for myself, my spouse/domestic partner and all dependents.
- ○ I decline dental plan coverage for:
  - ○ My spouse/domestic partner only
  - ○ My children only
  - ○ My spouse/domestic partner and children
  - ○ The following dependents only:

Reason for declining coverage:

- ○ Covered by another employer's health plan (e.g., through your spouse/domestic partner)
  - Carrier name
  - ID number
- ○ Covered by an individual health or dental plan
  - Carrier name
  - ID number
- ○ Covered by Medicare, Medi-Cal, Healthy Families Program
- ○ Covered by TRICARE
- ○ No other employer health coverage
- ○ Covered by another dental plan
  - Carrier name
  - ID number
- ○ Other

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/domestic partner, and/or my dependent(s) in my employer Blue Shield of California/Blue Shield of California Life & Health Insurance Company 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 31 days (60 days, if Medi-Cal or Healthy Families coverage is lost) 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 31 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 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

Date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

Employers must retain a copy of any signed personal refusal of coverage for their records.

An Independent Member of the Blue Shield Association