

## Refusal of Personal Coverage

(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 Name	Social Security Number
Employer (Group) Name	Hire Date
Marital Status Married <input type="checkbox"/> Yes <input type="checkbox"/> No Domestic Partnership <input type="checkbox"/> Yes <input type="checkbox"/> No	Job Title
Are you a full-time employee, working at least 30 hours per week for this employer? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain:	

Declining Coverage For:	Reason For Declining Coverage
<input type="checkbox"/> I decline health plan coverage for myself, my spouse/domestic partner, and all dependents. <input type="checkbox"/> I decline health plan coverage for: <input type="checkbox"/> My spouse/domestic partner only <input type="checkbox"/> My children only <input type="checkbox"/> My spouse/domestic partner and children <input type="checkbox"/> The following dependents only: _____ _____	<input type="checkbox"/> Covered by another employer's health plan (e.g., through your spouse/domestic partner). Carrier Name _____ ID Number _____ <input type="checkbox"/> Covered by an Individual Health Plan. Carrier Name _____
<input type="checkbox"/> If dental offered, I decline dental coverage for myself, my spouse, and all dependents.	<input type="checkbox"/> Medicare. <input type="checkbox"/> Covered by TRICARE. <input type="checkbox"/> No other employer health coverage. <input type="checkbox"/> Covered by another dental plan. Carrier Name _____ ID Number _____
<input type="checkbox"/> I decline dental plan coverage for: <input type="checkbox"/> My spouse/domestic partner only. <input type="checkbox"/> My children only. <input type="checkbox"/> My spouse/domestic partner and children. <input type="checkbox"/> The following dependents only: _____ _____	<input type="checkbox"/> 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 Life 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/domestic partnership, 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/domestic partnership, 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