Refusal of Personal Coverage

blue of california

Blue Shield of California and Blue Shield of California Life & Health Insurance Company

Blue Shield plans for groups with 2 to 50 eligible employees

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

Please type or print clearly. Use black ink.

Employee name	Social Security number	
Employer (group) name	Customer Number	Hire date (mm/dd/yyyy)
Marital status: Married ☐ Yes ☐ No Domestic partnership ☐ Yes ☐ No	Job title	

Are you a full-time employee, working at least 30 hours per week for this employer? ☐ Yes ☐ No Are you a part time employee, working at least 20 hours per week for this employer? ☐ Yes ☐ No If no, please explain:

Declining coverage for:

I decline health plan coverage for:

- ☐ Myself and all dependents
- ☐ My spouse/domestic partner only
- ☐ My children only
- ☐ My spouse/domestic partner and children
- ☐ The following dependents only:

_____

If dental plan offered, I decline dental plan coverage for:

- ☐ Myself and all dependents
- ☐ My spouse/domestic partner only
- ☐ My children only
- ☐ My spouse/domestic partner and children
- ☐ The following dependents only:

_____

If vision plan offered, I decline vision plan coverage for:

- ☐ Myself and all dependents
- ☐ My spouse/domestic partner only
- ☐ My children only
- ☐ My spouse/domestic partner and children
- ☐ The following dependents only:

_____

Reason for declining coverage

OTHER EMPLOYER HEALTH COVERAGE

- ☐ Enrolling as a dependent on this group health plan
- ☐ Covered by this employer's other health plan
- ☐ Covered by another employer's health plan (e.g., through your spouse/domestic partner)

  Carrier Name _____

  ID Number _____
- ☐ Covered by TRICARE

OTHER NON-EMPLOYER HEALTH COVERAGE

- ☐ Covered by an Individual health or dental plan

  Carrier Name _____

  ID Number _____
- ☐ Covered by Medicare, Medi-Cal or Health Families Program
- ☐ 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 loss of Medi-Cal or Healthy Families coverage) 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 _____

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