

Declination of Coverage

TO BE COMPLETED BY	EFFECTIVE DATE	CLASSIFICATION
LAST NAME:	FIRST NAME:	MI:
SOCIAL SECURITY NUMBER		

_____(INITIAL) I am rejecting Employee and/or Dependent Coverage. I certify that I have been given the opportunity to participate in the group health insurance plan offered by my employer and have declined to participate. I understand that the individual mandate from Health Care Reform requires that almost all individuals must obtain minimum essential health coverage or potentially pay a tax (Please visit coveredca.com for more information). I have declined to participate for the following reason (check one):

- ☐ An individual plan
- ☐ COBRA or State Continuation
- ☐ I and/or my dependents are currently not covered by any other health benefit plan
- ☐ Other (explain)_____
- ☐ My spouse's group coverage
- ☐ A government plan

I understand my next opportunity to enroll myself or my eligible dependents will be during the next open enrollment period, except under the conditions listed below.

Notice of Special Enrollment

If you are declining coverage for you and your dependent(s) because you and/or your dependent(s) have coverage elsewhere and you or your dependent(s) subsequently lose coverage, you may enroll yourself and your dependent(s) immediately, provided you notify the district within **30** calendar days of loss of coverage. In addition, if you have a new dependent as a result of marriage, birth, adoption, placement for adoption, or placed in your home as a result of court ordered custody or guardianship, you may enroll yourself and your dependent(s), provided you request enrollment within **30** calendar days of this event.

If you decline coverage and subsequently become a full-time employee, you must enroll in a plan the first of the month following the date of this event. If the number of work hours increases, you may choose to enroll the first of the month following the date of that occurrence.

Signature of Employee_____ Date_____

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