Insurance Coverage Declination Form

SECTION A: PERSONAL INFORMATION (to be completed by Employee)

Name of Company		Employer Phone Number
Employee Last Name	First Name	Middle Initial
Date of Hire	Employee Social Security Number	

Please complete this form ONLY if you do not want coverage for yourself and/or your dependents.

SECTION B: TYPE OF DECLINATION (check all that apply and include names of dependents)

I am declining coverage for:	Dental	Vision	CHIRO/ACU*
☐ Myself	☐	☐	☐
☐ Spouse or ☐ Domestic Partner Name: _____	☐	☐	☐
☐ Child(ren) Name: _____	☐	☐	☐
Name: _____	☐	☐	☐
Name: _____	☐	☐	☐

* Note that if an employee waives the group's medical coverage due to other group coverage or state sponsored coverage and the group offers Landmark Healthplans for Chiro/Acu, the employee may choose to enroll in the Chiro/Acu through the CBX if allowed by the employer.

SECTION C: REASON FOR DECLINING COVERAGE (must be filled out completely)

☐ **Other Group Coverage through a Spouse/Domestic Partner**

Plan	Carrier Name	Group #	Company Sponsor
Dental:			
Vision:			
Chiro/Acu			

☐ Individual Coverage: ☐ Medicare ☐ Medi-Cal ☐ IndividualPolicy ☐ Other Reason _____

SECTION D: SPECIAL ENROLLMENT RIGHTS

In certain circumstances, you and your eligible dependents may have rights to enroll outside the Open Enrollment period. To take advantage of special enrollment rights, you must request enrollment with the Contract Administrator (via your Employer) within 30 days of the event triggering special enrollment. Special enrollment rights may be triggered by any of the following events:

- If you or any of your dependents declined enrollment under this Plan because of other health insurance coverage, other than COBRA coverage, but afterwards lost eligibility for that coverage for any of the following reasons other than the failure to pay timely premiums or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the other plan):
  - Loss of eligibility for coverage as result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of the employee, termination of employment, and reduction in the number of hours of employment;
  - The other plan ceases to offer any benefits to the class of similarly situated individuals that includes you or your dependent (e.g., your dependent is a part time employee with employer A and employer A discontinues coverage for part-time employees);
- If you are covered under another plan for which an employer makes a contribution towards your premium and that contribution is terminated (such contributions must be completely terminated; a reduction in the value of the benefit or an increase in cost to the participant does not trigger a special enrollment right); or
- You exhaust COBRA coverage; or
- If you acquire a new dependent(s) as a result of marriage or domestic partnership, birth, adoption or placement for adoption, you may be able to add the new spouse or domestic partner or child(ren), or enroll yourself and your dependents.

SECTION E: YOUR LEGAL ACKNOWLEDGEMENT By signing, I understand that by failing to elect coverage now, I will not be able to enroll until the next Open Enrollment period or a Qualifying Event occurs as stated above. This declination provision will not apply if a Court orders coverage of a spouse or child and the request for enrollment follows the Special Enrollment Rights guidelines as stated above.

X _____ _____

EMPLOYEE SIGNATURE TO DECLINE COVERAGE **DATE**

PRINT NAME