SeeChange HEALTH

Coverage Declination Form

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Coverage Declination Form (Complete if your spouse, domestic partner or dependent(s) are refusing your employer's SeeChange Health Insurance Company, Inc. health plan coverage.)

Employee Name

Employer (Group) Name

Social Security Number

Marital Status ◯ Single ◯ Married ◯ Domestic Partner

Hire Date

Work Status ◯ Full Time ◯ Part Time ◯ Other

If you specified your work status as other, please explain

Declining coverage for:

◯ I decline health plan coverage for myself

◯ I decline health 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:

(Please check all the reasons that apply. If individuals are declining for different reasons, please indicate for each individual which reason applies.)

◯ **1. Covered by another employer's health plan**

Carrier name ____________________

ID Number ____________________

Name(s) ____________________
(If there are different reasons for declining cover for individuals)

◯ **2. Covered by other insurance plan**

Carrier name ____________________

ID Number ____________________

Name(s) ____________________
(If there are different reasons for declining cover for individuals)

◯ **3. Covered under government plan (Medicare, Healthy Families etc…)**

Please specify plan name ____________________

ID Number ____________________

Name(s) ____________________
(If there are different reasons for declining cover for individuals)

◯ **4. Other (Please explain)**____________________

Name(s) ____________________
(If there are different reasons for declining cover for individuals)

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 have made this decision voluntarily and no one has tried to influence me or put any pressure on me to decline coverage.
BY DECLINING THIS GROUP MEDICAL COVERAGE (UNLESS EMPLOYEE AND/OR DEPENDENT(S) HAVE GROUP MEDICAL COVERAGE ELSEWHERE), I ACKNOWLEDGE THAT MY DEPENDENT(S) AND I MAY HAVE TO WAIT UP TO TWELVE (12) MONTHS TO BE ENROLLED IN THIS GROUP MEDICAL PLAN. PREEXISTING CONDITIONS, WHEN ENROLLED IN THIS GROUP MEDICAL PLAN, MAY NOT BE COVERED FOR SIX (6) MONTHS.
In addition, If I acquire a new dependent as a result of marriage/domestic partnership, birth, adoption, or placement for adoption, I acknowledge that I, and any of the 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 of that qualifying event. 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.

Employee Signature ____ Date ______________

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