Refusal of Personal Coverage

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

Blue Shield plans for groups with 2 to 50 eligible employees

Effective July 1, 2008

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 of California Life & Health Insurance Company health plan coverage).
Please type or print. Use black ink.

Employee name	Social Security number
Employer (group) name	Hire date
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 If no, please explain:

Declining coverage for:

- ☐ I decline health plan coverage for myself, my spouse/domestic partner, and all dependents.
- ☐ I decline health plan coverage for:
  - ☐ My spouse/domestic partner only
  - ☐ My children only
  - ☐ My spouse/domestic partner and children
  - ☐ The following dependents only:

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Reason for declining coverage

- ☐ Covered by another employer's health plan (e.g., through your spouse/domestic partner)

  Carrier name ________________________________

  ID number ________________________________
- ☐ Covered by an individual health plan

  Carrier name ________________________________
- ☐ Medicare
- ☐ Covered by TRICARE
- ☐ No other employer health coverage
- ☐ Other ________________________________

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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 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 Date

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

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