CaliforniaChoice
Your Health. Your Choice.®

Medical / Dental Waiver

Complete this form only if you do not want medical or dental coverage for yourself and/or your eligible dependents. **If offered by your employer, the life coverage benefit cannot be waived and you are required to complete an Enrollment Application**. Chiropractic coverage cannot be waived when enrolling for medical coverage.

A. Personal Information

Name of Company	Employer Phone Number

Employee Last Name

Employee Social Security Number

Employee First Name

Group Number

B. Type of Waiver

I have been offered coverage by my employer, but at this time I wish to DECLINE coverage as follows:

1) **Medical for:** ❑ Myself and dependents ❑ Spouse/Domestic Partner ❑ Child(ren)

2) **Dental for:** ❑ Myself and dependents ❑ Spouse/Domestic Partner ❑ Child(ren)

C. Reason

Required only if employee waiving coverage

1) **Reason waiving Medical:**

- ❑ Other group coverage Carrier Name: ________________________ Group # ____________
- ❑ Medicare
- ❑ Medi-cal
- ❑ Individual Policy
- ❑ Other Reason: ____ (explanation required)

2) **Reason waiving Dental:**

- ❑ Other group coverage Carrier Name: ________________________ Group # ____________
- ❑ Medicare
- ❑ Medi-cal
- ❑ Individual Policy
- ❑ Other Reason: ____ (explanation required)

D. Signature

✗ I understand that by failing to elect coverage now, California*Choice* Benefit Administrators can impose up to a 12 month period of exclusion should I request coverage at a later date.

✗ I also understand that if my employer is offering life coverage, I CANNOT WAIVE LIFE COVERAGE.

This waiver provision will not apply if: 1) Court orders coverage of a spouse or child and the request for enrollment occurs within 30 days of the court order; or 2) Employee meets ALL of the following: A) Was covered under another employer-sponsored health plan at the time of initial eligibility; B) Lost coverage as a result of termination of employment, change in employment status, involuntary termination of other plan's coverage, cessation of employer's contribution, or death or divorce of spouse; C) Requests enrollment within 30 days of loss of coverage.

Employee **SIGN HERE TO WAIVE COVERAGE:**	Date
➡	