

MEDICAL / DENTAL WAIVER

IMPORTANT!

Complete this page 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:

- Medical for:** Myself and dependents Spouse/Domestic Partner Child(ren)
- Dental for:** Myself and dependents Spouse/Domestic Partner Child(ren)

C. Reason


Required only if employee waiving coverage—not required if waiving coverage for dependents only

- Reason waiving Medical:**
 Other group coverage Carrier Name: _____ Group # _____
 Medicare
 Medi-cal
 Individual Policy
 Other Reason: _____ (explanation required)
- 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, CaliforniaChoice® 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
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