



**DECLINATION OF MEDICAL/DENTAL COVERAGE FORM**

(To be completed if any coverage is declined by an eligible employee and/or their eligible dependents)

Declining **Medical** coverage for:       Self       Spouse       Dependents

Declining **Dental** coverage for:       Self       Spouse       Dependents

**Reason for declining coverage:** (check one)

Covered by another **Group** insurance policy.

Name of Group Providing Coverage: \_\_\_\_\_

**Please provide a copy of your insurance ID card.**

Covered by an Individual Policy.

Spouse covered by employer's Group medical plan. Carrier Name: \_\_\_\_\_

Other (explain): \_\_\_\_\_

I acknowledge that the available coverages have been explained to me by my employer and I know that I have the right to apply for coverage. I have been given the chance to apply for this coverage and I have decided not to enroll myself and/or my dependents, 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, I acknowledge that my dependents and I have to wait until the Open Enrollment period or a qualifying event. Additionally, by signing below I certify that the reason I am declining coverage is accurate as indicated by the check marks above.**

\_\_\_\_\_  
Company Name

\_\_\_\_\_  
Employee Social Security Number

\_\_\_\_\_  
Employee Name (Please Print)

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date