DECLINATION OF COVERAGE

District Office Use Only:

☐ New Hire

☐ Open Enrollment

☐ Qualifying Event

Due to ACA (Affordable Care Act) guidelines, a Declination of Coverage Form must be completed by any employee who is declining Medical benefits with Ceres Unified School District Health. By signing this form, you are attesting that you and all members expected to be included in your tax filings, have other Group coverage (excluding private plans on or off of the State Exchange), for the 2019-20 Plan Year.

SISC – MEDICAL BENEFITS

Employee Name: _____ Date of Birth: _____

Social Security Number: _____

I certify that the reason I am declining enrollment in Medical Benefits is: *(check one)*

☐ I am declining Medical benefits for myself and members of my tax family because we are enrolled in another Group Health plan (excluding private plans on or off of the State Exchange), for the **2019-20 Plan Year**. (Verification of other coverage for employee only is required and employee hire date must be prior to 1/1/2012).

☐ I am declining Medical benefits for myself only because I am enrolled in another Group Health plan, for the **2019-20 Plan Year**. (Verification of other coverage required and employee hire date must be prior to 1/1/2012).

☐ I am a classified employee and I am hired for 7 hours or less per day.

CRSIG – DENTAL/VISION

☐ Declining Dental ☐ Declining Vision

I decline coverage for :					
	First Name	Middle	Last Name	SSN	DOB
Employee					
Spouse					
Child					
Child					
Child					
Child					

I understand that by declining coverage, I will not be able to enroll in any benefits until the Districts Annual Open Enrollment period for an October 1st effective date, unless a qualifying event takes place. (Under IRS Section 125, a qualifying event may include marriage, death, divorce, birth, loss of coverage, etc.) If this occurs, I understand that I have 30 days from the date of the qualifying event to enroll in benefits and documentation will be required. If I am a retiree, I understand that I will not be able to re-enroll in any benefits I choose to terminate, in the future.

Signature: _____ Date: _____