# DIOCESE OF SACRAMENTO
# REFUSAL OF PERSONAL COVERAGE - (Complete if applicable)

## SECTION 1

EMPLOYEE NAME: _____

SSN: _____ DATE OF HIRE: _____

MARITAL STATUS: MARRIED ☐ YES ☐ No

I AM REFUSING: ☐ HEALTH ☐ VISION

☐ DENTAL - I understand that if dental coverage has been refused, I am not entitled to benefits under that coverage and that if I want to apply later, I understand I will not be entitled to benefits until the expiration of the Late Entrant Limitation period specified in the policy.

COVERAGE FOR (please check one box only):

☐ Myself, my spouse and all dependents (if any) ☐ My spouse and all my dependents

☐ The following dependents only: #1 _____ #2 _____

#3 _____ #4 _____

## SECTION 2
***(Must be completed)***

REASON FOR DECLINING COVERAGE (please check one box only)

☐ THE INDIVIDUALS REFUSING COVERAGE DO NOT HAVE ANOTHER EMPLOYER HEALTH/DENTAL/VISION BENEFIT PLAN.

I have been notified that I, and any dependents I may have, are eligible for enrollment in my employer's health/dental/vision benefit plan. By signing below, I voluntarily decline to enroll the individuals shown above, acknowledging that my failure to now elect coverage permits my employer's health/dental/vision benefit plan to impose a twelve-month exclusion from coverage following application and a six-month pre-existing condition exclusion upon enrollment, should these individuals later apply for coverage.

☐ THE INDIVIDUALS REFUSING COVERAGE HAVE

☐ ANOTHER EMPLOYER HEALTH/DENTAL/VISION BENEFIT PLAN.
NAME OF CARRIER: _____

☐ INDIVIDUAL PLAN THROUGH SEPARATE HEALTH/DENTAL/VISION CARRIER.
NAME OF CARRIER: _____

I have been notified that I, and any dependents I may have, are eligible for enrollment in my employer's health/dental/vision plan. I voluntarily decline to enroll the individuals shown above. By signing below, I certify that the reason I am declining enrollment for these individuals is that these individuals are now covered under another health/dental/vision plan.

I acknowledge that, if these individuals involuntarily lose coverage under the other employer health/dental/vision benefit plan, I must request enrollment for them in employer's health benefit plan within 30 days. Otherwise, I understand that my employer's health benefit plan may impose a twelve-month exclusion, from coverage following application and a six-month pre-existing condition exclusion upon enrollment.

## SECTION 3
***(Signature required for Refusal of Coverage only)***

X _____ _____

Signature of Employee Date