Declination of group medical coverage form

Section 1 > Employer information

Employer name

Section 2 > Patient information

I hereby acknowledge that I have been offered group medical coverage under my employer's plan for myself and/or my dependents. However, I am declining coverage for: (check one)

☐ **Myself** (employee only coverage)

☐ **My eligible family members only** (spouse/partner and/or dependent children)

☐ **Myself and my eligible family members** (employee and dependent coverage)

I decline coverage for myself and/or my family members due to the following reason: (check one)

☐ **Group coverage through spouse, partner or parent's employer**

☐ **Group coverage through a second employer**

☐ **Coverage through Medicare, Medicaid or Veteran's Affairs**

☐ **Cost / premium contribution**

☐ **Other** (specify reason) ______________________________

Section 3 > Authorization

Late Enrollee
I understand that if I do not enroll myself and/or my eligible dependents within 31 days of first becoming eligible, I may do so later as a "late enrollee." I understand that as a late enrollee, I am only eligible to enroll during my group's annual open enrollment period. Special Enrollment rights are explained below.

Special Enrollment
I further understand that the following special enrollment rights apply:

> If declination of enrollment is due to other health coverage, I may request enrollment of myself and/or my dependents within 31 days after the other coverage ends.

> For new dependents as a result of marriage or registration of domestic partnership, I may request enrollment of myself and/or the new dependents within 31 days after marriage or registration.

> For newborns, adopted children, or children placed for adoption, I may request enrollment of myself, my spouse or domestic partner, and/or these children within 60 days of birth, adoption or placement.

> For eligibility for premium assistance subsidy under Medicaid or CHIP, loss of coverage under Medicaid or CHIP or determination by the Department of Social and Health Services to enroll a child on an available group health plan, I may request enrollment of myself and the affected dependents within 60 days of the qualifying event.

Employee name *(print)*	
Employee signature X	Date

Ready to submit? Mail or fax this form to Moda Health:

Mail: Moda Health Sales and Service, Attn: 10th Floor, Moda Health, 601 S.W. Second Ave., Portland, OR 97204

Fax: 503-243-3949

Questions? Contact the Moda Health Sales and Service Department at 800-578-1402. TTY users, please dial 711.

modahealth.com

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