Declination of Coverage

TO BE COMPLETED BY GROUP ADMINISTRATOR ONLY	GROUP/PROSPECT NUMBER	EFFECTIVE DATE	ADMINISTRATOR NAME

EMPLOYEE NAME	LAST	FIRST	MIDDLE

SOCIAL SECURITY NUMBER	DATE OF FULL-TIME EMPLOYMENT	DATE OF BIRTH

GROUP NAME

GROUP ADDRESS

Check One Only: ☐ I am rejecting Employee Coverage   ☐ I am rejecting Dependent/Spouse Coverage

I certify that I have been given the opportunity to participate in the group health insurance plan offered by my employer and have declined to participate. I have declined to participate for the following reason (check one):

☐ Another plan offered by my employer   ☐ My spouse's group coverage

☐ An individual plan   ☐ A government plan (type)

☐ COBRA or State Continuation   ☐ I and/or my dependents are currently not covered by any other health benefit plan

☐ Other (explain): _____

Names of any dependents rejecting coverage for this group plan:

_____

I understand that if I elect to apply for coverage for myself, my spouse, and/or my dependent children through this employer health benefit plan at a later time, the application may be subject to an extended waiting period for pre-existing conditions or I may be delayed until the employer's open enrollment period.

Important Notice of Special Enrollment

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance (including Medicaid or Children's Health Insurance Program (CHIP)) or group health plan coverage, you may be able to enroll yourself and the dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (other than Medicaid or CHIP) or if the employer stops contributing towards your or your dependents' other coverage and within 60 days after the loss of Medicaid or CHIP eligibility.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption or foster care, except when adding a dependent child will not change your coverage type or premiums that are owed.

For questions or to obtain more information, contact a BCBSNC Customer Service representative at:

BCBSNC Customer Service
Blue Cross and Blue Shield of North Carolina
PO Box 2291 • Durham, NC 27702
1-877-258-3334 (toll-free)

Signature of Employee _____ Date _____
Notice of Declination of Coverage must be received by Blue Cross and Blue Shield of North Carolina within 30 days of the date that employee is first eligible for coverage.

Your plan for better health.™ | bcbsnc.com

BlueCross BlueShield of North Carolina