TW
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DECLINATION OF COVERAGE FORM

I hereby decline the health coverage offered for the following persons:

Self:	SSN#

Check reason:

☐ I am covered under another plan

☐ I am not covered under another plan, but do not choose to enroll at this time

Spouse:	SSN#

Check reason:

☐ I am covered under another plan

☐ I am not covered under another plan, but do not choose to enroll at this time

Child:	SSN#

Check reason:

☐ I am covered under another plan

☐ I am not covered under another plan, but do not choose to enroll at this time

Child:	SSN#

Check reason:

☐ I am covered under another plan

☐ I am not covered under another plan, but do not choose to enroll at this time

[Fill out a statement for each individual eligible for coverage, but for whom you are declining coverage. Use the back of this form if necessary.]

"Note: If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, or adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, or adoption."

Employee name (print or type)

Employee Signature

Date