



# Refusal of Coverage form

Effective January 1, 2026

Complete this form if you, your spouse, domestic partner, or child dependent(s) are refusing this group health, dental, vision, and/or life insurance coverage offered through the employer. (The employer must retain a copy of this form to provide to Blue Shield upon request). Please type or print. Use black ink. \*Note: The employee's Social Security number is required for all eligible employees.

Employee name Social Security number Date of birth

Employer (Group) name Hire date State of residence

Marital status Married Yes No Domestic partnership Yes No Job title

I am a permanent full-time employee actively working at least 30 hours per week for this employer. Yes No Or I am a permanent part-time employee actively working at least 20 hours per week for this employer. Yes No

Declining coverage for: Reason employee or dependent is declining health coverage Other employer health coverage Other non-employer health coverage

If dental plan offered, I decline dental plan coverage for: Reason employee or dependent is declining dental coverage Other dental coverage

If vision plan offered, I decline vision plan coverage for: Reason employee or dependent is declining vision coverage Other vision coverage

If life insurance plan offered, I decline life plan coverage for: Reason employee or dependent is declining life insurance coverage Other life insurance coverage Other reasons

I acknowledge that the coverage available to me has been explained to me by my employer. I know that I have every right to enroll in this coverage, and I have decided not to enroll myself and/or my dependent(s), if any. I now decline to enroll myself, my spouse/domestic partner, and/or my child dependent(s) in my employer's group health plan. I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to decline coverage. If I am declining enrollment for myself or my dependents because of other health coverage or because the employer stops contributing toward this coverage, I acknowledge that I may be able to enroll myself and my dependents in this plan if I request enrollment within 60 days after my or my dependents' other coverage ends or after the employer stops contributing toward the other coverage. In addition, if I acquire a new dependent as the result of marriage/domestic partnership, birth, adoption, or placement for adoption, I acknowledge that I, and my dependents, may request enrollment in my employer's health plan by applying for that coverage within 60 days of the marriage/domestic partnership, birth, adoption, or placement for adoption. I also acknowledge that if I, or my dependents, become eligible for the Healthy Families or the Medi-Cal Premium Assistance programs, I or my dependents may request enrollment in my employer's health plan by applying for coverage within 60 days of the notice of eligibility for these premium assistance programs. If I have indicated above that the reason for declining coverage for myself or my dependent(s) is coverage under another employer health benefit plan, I acknowledge that if I or my dependent(s) involuntarily lose coverage under the other employer health benefit plan, I must request enrollment for myself and/or my dependent(s) in my employer health benefit plan within 60 days. Otherwise, I understand I may not enroll myself and/or my dependents in my employer's health plan until the end of my employer's next open enrollment period or 12 months (whichever is earlier).

For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Signature of employee Date