

Declination of Coverage Form

CERTIFICATION OF OTHER COVERAGE

I understand that I have been offered coverage through my employer in Western Health Advantage (WHA). I voluntarily choose not to enroll in WHA through my employer at this time. I understand my next opportunity to enroll myself or my eligible dependents will be during my employer's open enrollment period, which may be up to 12 months from the date I sign this form. WHA's Evidence of Coverage and Disclosure Form informs me and my employer of special enrollment rights due to: (1) to the birth or adoption of a dependent, and (2) to loss of other coverage.

Group Name _____ Group # _____

Employee First Name _____ Last Name _____

I am declining coverage for the reason checked below:

For Myself

I am covered as a dependent through another employer's health plan

I am covered under COBRA continuation coverage, Access for Infants and Mothers (AIM) Health Families, or Medi-Cal

Other _____

For My Spouse/Domestic Partner Only

For Children Only

For My Spouse/Domestic Partner and Children

Each dependent not enrolled is covered as an employee or dependent under another employer's health benefit plan

Each dependent not enrolled is covered under COBRA continuation coverage, Access for Infants and Mothers (AIM) Health Families, or Medi-Cal

Other _____

Employee Signature _____ Date _____