Declination of Coverage

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:

☐ Myself

- ☐ I am covered as a dependent through another employer's health benefit plan
- ☐ I am covered under COBRA continuation coverage, Access for Infants and Mothers (AIM), Healthy Families, or Medi-Cal
- ☐ Other: _____

☐ Spouse/Domestic Partner only ☐ Child(ren) only ☐ Spouse/Domestic Partner and Child(ren)

- ☐ 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), Healthy Families, or Medi-Cal
- ☐ Other: _____

Employee Signature _____ Date _____