Health Net®

Health Net®
LIFE INSURANCE COMPANY

Member Declination *of* Coverage

Complete this form if any coverage is to be declined by you or your eligible dependents.

Employee personal information

Last name:	First name:	MI:
Social Security # / Matricula ID #:	Date of full-time employment:	
Employer name:		
Employer address:		

Declination of coverage

Declining **medical** coverage for: ☐ Self ☐ Spouse ☐ Domestic partner ☐ Dependent(s)

Name: _____

Reason: ☐ Other group coverage through this employer
☐ Individual coverage
☐ Other group coverage by another group (i.e., spouse's employer)
☐ Other: _____

Declining **dental** coverage for: ☐ Self ☐ Spouse ☐ Domestic partner ☐ Dependent(s)

Name: _____

Reason: ☐ Other group coverage through this employer
☐ Individual coverage
☐ Other group coverage by another group (i.e., spouse's employer)
☐ Other: _____

Declining **vision** coverage for: ☐ Self ☐ Spouse ☐ Domestic partner ☐ Dependent(s)

Name: _____

Reason: ☐ Other group coverage through this employer
☐ Individual coverage
☐ Other group coverage by another group (i.e., spouse's employer)
☐ Other: _____

Stop and read carefully

The available coverages have been explained to me by my employer. I have been given the chance to apply for the available coverages. I have decided not to enroll myself and/or my dependent(s).

By declining coverage, I acknowledge that my dependents and I may have to wait to be enrolled until the next Open Enrollment Period or qualifying event. Additionally, by signing below I certify that the reason I am declining coverage is accurate as indicated by the check marks above.

Employee signature: _____ **Date:** _____

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