Declination of Coverage

TO BE COMPLETED BY GROUP ADMINISTRATOR ONLY	GROUP NUMBER	EFFECTIVE DATE	ADMINISTRATOR NAME

EMPLOYEE NAME LAST	FIRST	MIDDLE
SOCIAL SECURITY NUMBER	DATE OF FULL-TIME EMPLOYMENT	DATE OF BIRTH
GROUP NAME		
GROUP ADDRESS		

CHECK ONE ONLY: ☐ I am rejecting Employee Coverage ☐ I am rejecting Dependent/Spouse Coverage

I certify that I have been given the opportunity to participate in the group health insurance plan offered by my employer and have declined to participate. I have declined to participate for the following reason (check one):

☐ Another plan offered by my employer
☐ An individual plan
☐ COBRA or State Continuation
☐ My spouse's group coverage
☐ A government plan (type)
☐ I and/or my dependents are currently not covered by any other health benefit plan

☐ Other (explain): _____

Names of any dependents rejecting coverage for this group plan:

_____

I understand that if I elect to apply for coverage for myself, my spouse, and/or my dependent children through this employer health benefit plan at a later time, the application may be subject to an extended waiting period for pre-existing conditions or I may be delayed until the employer's open enrollment period.

Important Notice of Special Enrollment

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and the dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within "30 days" or any longer period that applies under the plan after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within "30 days" or any longer period that applies under the plan after the marriage, birth, adoption, or placement for adoption or foster care.

For questions or to obtain more information, contact a BCBSNC Customer Service representative at:

BCBSNC Customer Services
1-877-258-3334

Signature of Employee _____ Date _____

Notice of Declination of Coverage must be received by Blue Cross and Blue Shield of North Carolina within 30 days of the date that employee is first eligible for coverage.