

**Blue Shield of California and  
Blue Shield of California Life & Health Insurance Company**

Blue Shield plans for groups with 2 to 50 eligible employees

**Effective January 1, 2009**

(Complete if you, your spouse, domestic partner, or dependent(s) are refusing your employer's Blue Shield of California/Blue Shield of California Life & Health Insurance Company health and/or dental plan coverage).

**Please type or print. Use black ink.**

Employee name	Social Security number
Employer (group) name	Hire date
Marital status Married <input type="checkbox"/> Yes <input type="checkbox"/> No Domestic partnership <input type="checkbox"/> Yes <input type="checkbox"/> No	Job title
Are you a full-time employee, working at least 30 hours per week for this employer? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain:	

Declining coverage for:	Reason for declining coverage
<input type="checkbox"/> I decline health plan coverage for myself, my spouse/domestic partner, and all dependents.	<input type="checkbox"/> Covered by another employer's health plan (e.g., through your spouse/domestic partner) Carrier name _____ ID number _____
<input type="checkbox"/> I decline health plan coverage for: <input type="checkbox"/> My spouse/domestic partner only <input type="checkbox"/> My children only <input type="checkbox"/> My spouse/domestic partner and children <input type="checkbox"/> The following dependents only: _____ _____	<input type="checkbox"/> Covered by an individual health or dental plan Carrier name _____ <input type="checkbox"/> Medicare <input type="checkbox"/> Covered by TRICARE <input type="checkbox"/> No other employer health coverage <input type="checkbox"/> Covered by another dental plan. Carrier name _____ ID number _____
<input type="checkbox"/> If dental offered, I decline dental coverage for myself, my spouse/ domestic partner, and all dependents.	<input type="checkbox"/> Other _____ _____
<input type="checkbox"/> I decline dental plan coverage for: <input type="checkbox"/> My spouse/domestic partner only <input type="checkbox"/> My children only <input type="checkbox"/> My spouse/domestic partner and children <input type="checkbox"/> The following dependents only: _____ _____	

I acknowledge that the coverage available to me has been explained to me by my employer, and 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 dependent(s) in my employer Blue Shield of California/Blue Shield of California Life & Health Insurance Company 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 31 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 any dependents I may have, may request enrollment in my employer's health plan by applying for that coverage within 31 days of the marriage/domestic partnership, birth, adoption, or placement for adoption.

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 31 days. Otherwise, I understand I may not enroll myself and/or my dependents in my employer's health plan until the earlier of the end of my employer's next open enrollment period or 12 months.

Signature of employee

Date

**Employers must retain a copy of any signed personal refusal of coverage for their records.**