NC MS *North Carolina Medical Society Employee Benefit Plan*

Declination of Coverage

TO BE COMPLETED BY GROUP ADMINSTRATOR ONLY
Group No: _____
Effective Date: _____
Admin. Name: _____

EMPLOYEE NAME: LAST	FIRST	MIDDLE
DATE OF FULL-TIME EMPLOYMENT	DATE OF BIRTH	SOCIAL SECURITY NUMBER
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 ☐ A government plan (type): _____
☐ My spouse's group coverage ☐ COBRA or State Continuation
☐ An individual plan ☐ Other (explain): _____
☐ I and/or my dependents are currently not covered by any other health benefit plan.

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 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 (including Medicaid or Children's Health Insurance Program (CHIP)) or group health plan coverage, you may in the future be able to enroll yourself or your 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 after you or your dependents' other coverage ends (other than Medicaid or CHIP) or if the employer stops contributing towards your or your dependents' other coverage and within 60 days after the loss of Medicaid or CHIP eligibility.

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 after the marriage, birth, adoption, or placement for adoption or foster care.

Signature of Employee: _____ Date: _____

Notice of Rejection of Coverage must be received by the North Carolina Medical Society Employee Benefit Plan within 30 days of the date that employee is first eligible for coverage.