

City of Long Beach 2020

EMPLOYER HEALTH BENEFITS WAIVER OF COVERAGE

If you are declining enrollment for yourself or your dependents (including your spouse) under this plan because you have other health coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment **within 30 days** after your other coverage involuntarily ends.

In addition, if you are not enrolled under your employer's group health plan and 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 provided that you request enrollment within 30 days after marriage, birth, adoption or placement.

If you are declining coverage, please check one of the following reasons:

I decline coverage for:

- Myself
- Spouse
- Dependent Children
- Myself and all dependents

Declining coverage due to existence of other coverage: **(Attach Copy of Your Proof)**

- Spouse's Employer's Plan
- Individual Plan
- Covered by Medicare
- Medicaid
- COBRA from Prior Employer
- VA Eligibility
- I (we) have no other coverage at this time
- Other _____

I understand that by waiving coverage at this time, I will not be allowed to participate unless I qualify at a special enrollment period or as a late enrollee, if applicable, or at the next open enrollment period. I acknowledge that I have been given the opportunity to enroll in the City of Long Beach medical plan.

Date: _____

Signature: _____

Printed Name: _____

Social Security Number: _____