SADDLEBACK VALLEY UNIFIED SCHOOL DISTRICT
DECLINATION OF PERSONAL COVERAGE FORM

(Complete if you are declining any/all portion(s) of your health benefit plan or declining on behalf of a spouse/domestic partner or dependent.)

IF YOU ARE DROPPING BENEFITS, A CHANGE FORM MUST ALSO BE COMPLETED

EMPLOYEE INFORMATION

1	EMPLOYEE PIN	LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH

DECLINATION OF COVERAGE

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CHECK PLANS THAT YOU ARE DECLINING:

☐ Medical/Behavioral Health ☐ Dental/Vision

Spouse/Dependents must have the coverage as the employee.

If the employee is declining medical/behavioral health coverage but maintaining dental and/or vision, a completed a Subscriber Enrollment Form must be attached to provide enrollee information.

REASON FOR DECLINING COVERAGE

NOTE: You may not decline Life Insurance if you are eligible. Please complete the Beneficiary Designation section below.

☐ I decline the above checked coverage for myself, my spouse/domestic partner, and all dependents.

☐ I decline the above checked coverage for the following dependents:

- ☐ Spouse/Domestic Partner
- ☐ Children
- ☐ Only Children Listed Below Only:

_____

_____

_____

_____

☐ Covered by another employer's health plan – through spouse/domestic partner or through COBRA with a former employer.

☐ Covered by an Individual Health Plan.

☐ Covered by another SVUSD employee's health plan.

☐ Medicare

☐ Other: _____

LIFE INSURANCE (Eligibility: SVEA/SVMTA/SVPSA-50% or more of a 40-hr work week; CSEA-More than 30 hours per week)

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PRIMARY LIFE INSURANCE BENEFICIARY(IES): (For additional Beneficiaries, attach a list)

NAME:	RELATIONSHIP:	SOCIAL SECURITY #:	Percentage*
FULL ADDRESS:		DATE OF BIRTH:	%
NAME:	RELATIONSHIP:	SOCIAL SECURITY #:	%
FULL ADDRESS:		DATE OF BIRTH:	

CONTINGENT LIFE INSURANCE BENEFICIARY(IES): Applicable only if you are not survived by one or more primary beneficiaries.

NAME:	RELATIONSHIP:	SOCIAL SECURITY #:	%
FULL ADDRESS:		DATE OF BIRTH:	
NAME:	RELATIONSHIP:	SOCIAL SECURITY #:	%
FULL ADDRESS:		DATE OF BIRTH:	

This beneficiary designation revokes all prior beneficiary designation. Unless you indicate otherwise, if any beneficiary predeceases you, that beneficiary's share will be divided pro-rata among the surviving beneficiaries of the same class-primary or contingent. If no beneficiary survives you, primary or contingent, payment will be made pursuant to the terms of the application policy. ***** If no percentages are noted, benefits will be divided equally between the same beneficiary class.

EMPLOYEE SIGNATURE: _____ DATE: _____

ACKNOWLEDGEMENT

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I acknowledge that the coverage available to me has been explained to me by the District and I know that I have every right to enroll in this coverage and I have decided not to enroll myself and/or my dependents(s), if any. I now decline to enroll myself, my spouse/domestic partner and/or my dependent(s) in the District's coverage checked above. I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to decline coverage. I am aware that I will lose some special enrollment rights for myself and my dependents if I decline coverage because I or my dependents have other coverage, unless I give the Plan this written statement that the reason for declination is because I or my dependents have other coverage.

Change of Family Status and Special Enrollment: If I acquire a new dependent as the result of marriage, birth, adoption or placement for adoption, I acknowledge that I, and my eligible dependents may request enrollment in my employer's health plan by applying for that coverage within 31 days of the marriage, birth, adoption, or placement for adoption.

Involuntary Loss of other coverage (employer or COBRA): 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 the District's health plan(s) within 31 days. Otherwise, I understand I may not enroll myself and/or my dependents in the District's health plan(s) until the earlier of the end of the next open enrollment period or 12 months.

EMPLOYEE SIGNATURE: _____ DATE: _____