



Health Net®

Request for Waiver of Coverage

Group and Employee Information

Employer Name _____

Address _____

Employee Name SSN# _____

Spouse (If applicable) SSN# _____

Domestic Partner (If applicable) SSN# _____

Dependent Child(ren) SSN# _____

Request for Waiver of Coverage

I decline to enroll in the health plan offered by my employer for the following reason:

- Existence of other coverage
- Coverage not desired

I decline coverage for:

- Myself
- Myself and all my eligible dependents
- My spouse
- My spouse and eligible child(ren)
- My domestic partner (if applicable)
- My domestic partner and his/her eligible dependents (if applicable)

Notice of enrollment rights: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in the Health Net plan, provided that you request enrollment within 30 days after your other coverage ends. 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 in the Health Net Plan within 30 days [or within 31 days as defined in your contract] after the marriage, birth, adoption, or placement for adoption. If you fail to timely enroll, you may be treated as a late entrant.

I the undersigned have been offered and declined coverage under the Health Net benefit plan as indicated above.

Signature _____ Date _____

NE36660 (4/07) 6013204

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