



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

Declination of Coverage Form

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

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 subject to an extended waiting period for preexisting conditions or I may be delayed until the employer's open enrollment period.

Signature of Employee _____ Date _____

Notice of Rejection of Coverage must be received by Blue Cross and Blue Shield of North Carolina within 30 days of the date that employee is first eligible for coverage.