



CALIFORNIA WAIVER OF GROUP MEDICAL COVERAGE

SSN: _____

CSA: _____

EMPLOYEE NAME & ADDRESS

EMPLOYER NAME AND ADDRESS

PLEASE LIST DATA FOR SELF AND ELIGIBLE DEPENDENTS/SPOUSE/MINOR CHILDREN:

FULL NAME	SSN:	REL. CODE	D.O.B.	WAIVE

I understand that I am waiving coverage for myself and/or eligible dependents as I/we are currently insured under another qualifying health benefit plan. I further understand by waiving coverage at this time, said plan may impose (should I/we later decide to apply for coverage under this plan) an exclusion from coverage for all medical conditions for a period of 12 months.

I understand that should I lose my current coverage under any other health benefit plan as a result of:

- Termination of employment of the person through whom I/we have coverage
- Termination of the plan of coverage
- Cessation of the employer's contribution towards an employee or dependent coverage
- Legal separation
- Divorce
- Reduction in hours of employment
- As a covered employee, a court has ordered that coverage be provided for a spouse or minor child
- As a dependent of an enrolled eligible employee, I have lost or will lose my no share-of-cost MediCal coverage

I will have 31 days to enroll in this plan of coverage. Failure to enroll within 31 days of loss of my existing coverage will again permit this plan to impose the exclusion cited above.

I do not wish to request coverage under the group contract(s) for reasons not mentioned above.

I am canceling coverage.

EMPLOYEE'S SIGNATURE:

DATE:

EMPLOYER'S SIGNATURE

DATE