



CERTIFICATION TO WAIVE/DECLINE COVERAGE

Do not complete unless waiving/declining coverage for you and / or your dependent(s).

PacAdvantage

Choice • Simplicity • Affordability

Please use black or blue ink. When you see a choice of one or more boxes, please put a X in the box that most accurately applies. Please write dates as Month / Day / Year.

REQUIRED INFORMATION

Group number(If applicable)

Employee or member social security number

Employee or member's first name

M.I.

Employee or member's last name

WAIVE COVERAGE SECTION

Please complete this section if you and/or your dependents are waiving coverage through PacAdvantage because you and/or your dependents have coverage through another source, such as a different employer or with Medicare or MediCal.

Check the statement(s) that apply to you:

I certify that I am waiving coverage through PacAdvantage because I have coverage through a different employer or have Medicare or MediCal coverage. If I do not enroll within 30 days of termination of my other coverage, I understand that I must wait until the next open enrollment period. I understand that if my other coverage terminates, I may apply for coverage through PacAdvantage and must do so within 30 days of termination of my other coverage.

I am waiving coverage for the following coverage types:

Medical only

Medical and all optional benefits offered by my employer

I certify that my dependents listed below are waiving coverage through PacAdvantage because the dependents listed have coverage through another source, such as a different employer or have Medicare or MediCal coverage. I understand that if other coverage for the listed dependents should terminate, I may enroll my eligible dependents for coverage through PacAdvantage and must do so within 30 days of termination of other coverage. If I do not enroll my dependents within 30 days, I understand I must wait until my employer's next open enrollment period.

DECLINE COVERAGE SECTION

Please complete this section if you and/or your dependents are eligible for coverage through PacAdvantage, but you wish to decline coverage.

Check the statement that applies to you:

I certify that I am eligible for coverage through PacAdvantage and I decline coverage for myself and my dependent(s). I understand that I cannot enroll in PacAdvantage until my employer's next open enrollment period.

I certify that my dependents listed below are eligible for coverage through PacAdvantage and I decline coverage for the dependents listed below in PacAdvantage until my employer's next open enrollment period.

LIST OF AFFECTED DEPENDENTS

Dependent's first name

M.I.

Dependent's last name

Spouse

Child

Other

Spouse

Child

Other

Spouse

Child

Other

SPOUSE

CHILD

OTHER

Sign and return this form to your employer. It must be retained for one year from the date of the signature.

Employee signature

Date signed