



**DECLINATION OF COVERAGE
(PLEASE PRINT OR TYPE IN INK)**

COMPANY NAME	DATE OF HIRE
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NOTICE AND CERTIFICATION OF COVERAGE DECLINATION. Must be completed if an eligible employee and/or family member declines coverage in a health plan offered by the HealthWay of San Diego County Trust Fund.

I decline coverage for:

	NAME (FIRST) (MIDDLE) (LAST)	SSN	DATE OF BIRTH MO-DAY-YR	CHECK DECLINING COVERAGE
Employee				
Spouse				
Child				
Child				
Child				
Child				

I understand that in the event I and/or my eligible dependents choose to enroll in the HealthWay Trust Fund at a later date, that we may be considered "Late Enrollees" and may have to wait for coverage for a period of twelve (12) months after the date we enroll.

I have been informed that under the three following circumstances, I and any of my eligible dependents will not be considered Late Enrollees, and thus, will not have to wait for a period of twelve (12) months after we enroll in the HealthWay Trust Fund:

1. OTHER EMPLOYER HEALTH BENEFIT PLAN COVERAGE. You and your dependents (collectively "You") shall not be considered Late Enrollees if:
 - a. You are covered under another employer health benefit plan ("Plan") although You are also eligible to enroll in the HealthWay of San Diego County Trust Fund;
 - b. You certify, in writing, on the Declination of Coverage that You are declining HealthWay Trust Fund coverage because You are already covered under another group Plan;
 - c. You learn at a later date that You have lost or will lose coverage under the other Plan because of: (1) the termination of your employment or the employment of the person through whom You are covered as a dependent; (2) a change in your employment status or the employment status of the person through whom You are covered as a dependent; (3) the termination of coverage under the other Plan; (4) the termination of an employer's monetary contribution toward your coverage under the other Plan; (5) the death of the person through whom You are covered as a dependent; or (6) the divorce from the person through whom You are covered as a dependent, and
 - d. You request enrollment within thirty (30) days after termination of your coverage under the other Plan due to the reasons stated above in Subsection 1(c).

If you meet each of the requirements listed above, You will not be classified as a Late Enrollee, and will not have to wait (12) months after You enroll.

2. MULTIPLE PLANS. If your employer offers one or more other Plans and You enrolled in one of such Plans during an open enrollment period, You will not be classified as a Late Enrollee if You enroll at a later date.
3. COURT ORDER. If a court has ordered that You obtain health care coverage for your spouse or minor child, and You submit an application for enrollment within thirty (30) days after issuance of the court order, you and your spouse and/or minor child will not be classified as Late Enrollees.

UNLESS ONE OF THE THREE CIRCUMSTANCES SET FORTH ABOVE APPLIES TO YOU, FAILURE TO ENROLL DURING THE INITIAL ENROLLMENT PERIOD WILL PERMIT THE PLAN TO TREAT YOU AS A LATE ENROLLEE AND TO IMPOSE, AT THE TIME OF YOUR LATER DECISION TO ENROLL, A TWELVE (12) MONTH WAITING PERIOD.

I CERTIFY THAT THE REASON I AM DECLINING ENROLLMENT IS: (check one)

- I am covered under another group health benefit plan offered to my spouse.
- I am covered under another group health benefit plan offered by my EMPLOYER.

X _____
Signature

Date (Mo/Day/Year)

If declining coverage for employee/dependent(s), please sign here.