

Declining Health Insurance Form

If you elect not to enroll in this health plan, it is important to complete this form for two reasons:

1. It will document your decision and may help you to re-enroll in the program in the future as a Special Enrollee as provided for by federal regulations.
2. It is a requirement for many persons who do not wish to enroll, due to Oklahoma's Small Employer Health Insurance legislation.

EMPLOYER INFORMATION			
NAME OF EMPLOYER			
EMPLOYEE INFORMATION			
LAST NAME	FIRST NAME	MIDDLE NAME	
ADDRESS	CITY	STATE	ZIP
SOCIAL SECURITY NUMBER _ _ - _ - _ _ _	SEX M <input type="checkbox"/> F <input type="checkbox"/>	HOURS WORKED PER WEEK	
REASON FOR DECLINING COVERAGE			
<ol style="list-style-type: none"> 1. <input type="checkbox"/> I am enrolled on my spouse's health insurance plan. 2. <input type="checkbox"/> I am enrolled on an individual health plan. 3. <input type="checkbox"/> I am not enrolled on any health insurance plan, but do not want this coverage. 4. <input type="checkbox"/> Other (please explain) _____ 			

NOTICE: If you are declining enrollment for yourself, your spouse or your dependents because of other health insurance coverage, you may in the future be able to enroll your spouse or your dependents on this plan provided you request Special Enrollment within 31 days after the other coverage ends.

Qualifying events for Special Enrollment include: termination of employment, reduction of work hours, legal separation, divorce, death, employer contributions toward the other coverage having been terminated or if COBRA/state mandated continuation of coverage has been exhausted. If you have a dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself, your spouse, and your dependents provided you request Special Enrollment within 31 days of the event.

Should you not enroll upon the initial offering of this coverage (Timely Enrollee) or not enroll as a Special Enrollee (noted in the first paragraph of this Notice); you, your spouse and/or your dependents may apply during the Open Enrollment period (31 days prior to your group's renewal date) as a Late Enrollee.

There is a Preexisting Condition limitation on the coverages available from the Plan (except for BlueLincs HMO coverage). A Preexisting Condition is a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period to your enrollment date. A Preexisting Condition will not apply to pregnancy or to a newborn or adopted child under age 18, provided the child becomes covered under the Contract/Agreement within 31 days of birth or adoption.

The length of the Preexisting Condition limitation is 12 months after the enrollment date for Timely and Special Enrollees, and 18 months for Late Enrollees.

The Preexisting Condition limitation waiting period may be reduced by the number of days you (and/or your spouse, and/or your dependents) were covered under a prior health insurance plan(s) should there be no more than a 63 day break in coverage, excluding your waiting period (if any). In order to reduce the Preexisting Condition period, you have the right to demonstrate prior creditable coverage. To do this you must request a Certificate of Coverage form from the prior health plan(s) or insurer and send it to our Enrollment Services Department. After the amount of prior creditable coverage has been determined, we will notify you of Preexisting Condition credit based on your prior coverage.

STATEMENT: I have been offered the benefits of the Blue Cross and Blue Shield of Oklahoma or BlueLincs HMO plan and have elected not to be covered under either benefit option. I understand the Notice above and do not wish to enroll as a Timely Enrollee.

EMPLOYEE SIGNATURE	DATE
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