DECLINATION OF COVERAGE

Sutter Health Plus

This form is used for employees declining coverage with Sutter Health Plus. Please complete, sign and return this form to your Human Resource Department and keep a copy of this form for your records.

Section A – Group Information

Group Name

Sutter Health Plus Group ID #

Section B – Employee Information

Employee Name

Section C – Declining Coverage

☐ **I voluntarily decline Sutter Health Plus coverage offered to me by my employer.**

Reason for Declining Coverage *(Please select all that apply):*

- ☐ I am covered by my spouse/domestic partner/parent's employer's health plan
- ☐ I am covered by an individual plan
- ☐ I am covered by another health plan
- ☐ I am covered by a Medicare plan
- ☐ I am covered by a Medi-Cal plan
- ☐ Other reason for declining:

Section D – Other Health Care Coverage *(Include additional pages if needed)*

Other Health Plan/Insurance Company Name

Policy Number

Policyholder/Subscriber's Name

Member ID #

Section E – Agreement

By signing this form, you are declaring that the information you have provided is true and complete. You understand that by declining coverage for yourself, you are also declining coverage for your eligible dependent(s). You may only enroll or change your coverage during your employer's annual open enrollment period determined by your employer. However, in some cases, you may qualify to enroll in a special enrollment period due to a qualifying event. For a list of qualifying events, please refer to the Sutter Health Plus *Evidence of Coverage and Disclosure Form*.

Signature

Date

Printed Name ***(First and last)***

Sutter Health Plus
Your Health Plan