WAIVER OF COVERAGE

This form must be completed whenever a member of the Diocese of California who is eligible for medical and dental benefit coverage for him/herself and or his/her dependents, but elects not to participate in the coverage either for him/herself and or his/her eligible dependents because coverage is provided through a spouse or other group plan.

Please complete in full

Employee Name:_________________________________ Effective Date (1st of mo):_______________

Social Security #:______________________ Parish/Institution & City:___________________________

During the initial enrollment period I decline to enroll myself and or any of my eligible dependent(s) for medical and or dental coverage under the plans offered by the Diocese of California. I list the full name, date of birth and relationship of all persons for whom I decline enrollment.

Name(s) include self and all dependents	Date of Birth	Relationship to Employee	Decline Medical	Decline Dental
		SELF		

I certify that I understand that if anyone listed on this form later wish group medical or dental coverage under the plans offered by the Diocese of California, that anyone so desiring coverage may be considered a **late enrollee**. Should I later choose to rescind this waiver and enroll myself and or my eligible dependents, the medical plan(s) may impose an exclusion from coverage until the next open enrollment period and the dental plan may require evidence of good dental health. However I and or my eligible dependent(s) will not be considered a late enrollee if I can prove that one of the following circumstances apply.
I and or any eligible dependent(s) were covered under another group plan as an employee or dependent) when first eligible to enroll for coverage under the Diocese of California's plan and that the group coverage is lost or will be lost as a result of:

1. change in marital status
2. change in number of dependents
3. change in employment status
4. change in residence that causes a loss of coverage
5. Dependent meeting or ceasing to meet the plan's definition of dependent

I request coverage under the Diocese of California's plan within 30 days after the termination of such other group coverage (or cessation of contribution by the other employer)

or

I elect for myself and or any eligible dependent(s) a different group medical plan (as may be offered by the Diocese of California) during an open enrolment period.

or

A court has ordered that medical coverage be provided for my spouse or dependent child(ren) and I request such coverage within 30 days after issuance of the court order.

I certify to the accuracy of the information presented here:

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signature date