WAIVER of Medical and/or Dental Coverage

This form must be completed whenever a full-time benefit eligible employee (one who is working at least 30hrs / week) of the Diocese of California elects not to participate in the employer provided coverage either for self and or their eligible dependents because other coverage is provided through their spouse or other group plan [non-ACA, aka "Obamacare"plan].

Employee Last Name:_____ First Name:_____

Social Security #:_____ Coverage waived Effective Date (1st of mo):_____

Employing congregation / institution, city & Parish Code:_____

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, including self, 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:

signature date