Ghirardelli ASSOCIATES

Decline/Waiver of Health Coverage

EMPLOYEE INFORMATION:

Name: _____(Please Print)

Address: _____

City/State/Zip: _____

Date of Birth: _____ SSN: _____

I acknowledge that I have been offered the opportunity to receive company paid for employee only health coverage for myself and my dependents through my employer.

I decline enrollment at this time because:

__ I have other medical coverage provided by:

Insurance company name: _____ Policy no.:_____

Through (employer name): _____

__ I do not wish to enroll myself in any type of medical coverage at this time.

__ I do not wish to enroll ☐ spouse ☐ child(ren) in any type of medical coverage at this time.

Decline/Waive: __ United Health Care __ Kaiser __ MetLife Dental __ VSP Vision

(please check all that apply)

If you are declining enrollment for yourself or dependents (including your spouse) because of other health care coverage, you may enroll yourself or your dependents in this plan prior to the next open enrollment period (under certain circumstances). To do this, you must have involuntarily lost your other coverage and we must receive your enrollment application within 30 days after your other coverage ended.

Additionally, if you have new dependents as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and dependents, provided we receive your completed enrollment applica-

Signature: _____

Date: _____