

**UCSF HUMAN RESOURCES
RESIDENTS & POSTDOCTORAL SCHOLARS HEALTH INSURANCE**

HEALTH INSURANCE COVERAGE DECLINATION OF ALL MEDICAL COVERAGES

INSTRUCTIONS

- Please read all information carefully
- Employer completes top portion of form
- Employee completes, signs and dates bottom portion of form

EMPLOYER INFORMATION

POLICY CARRIER/TYPE	POLICY NUMBER
UniCare Medical	1253VC
Health Net Medical	55509D/F
Delta Dental	510-0003
Vision Service Plan	12170630
MetLife and AD&D	113764
MetLife LTD	113764

EMPLOYEE INFORMATION

NAME (first, middle, last):

SOCIAL SECURITY NUMBER:

DATE OF HIRE (Or date of notification of insurance coverage):

UCSF DEPARTMENT/PROGRAM:

ALTERNATE HEALTH INSURANCE PROVIDED BY (Company name):

EMPLOYEE AUTHORIZATION

I do not wish to be covered for group medical, dental, vision, life, nor accidental death and dismemberment insurance. This refusal of coverage applies to myself as well as any of eligible dependents (if applicable).

I understand that failure to elect coverage at this time will cause myself and any of my dependents to be excluded from the available plans until the next period of Open Enrollment (June of each year with an effective date of July 1). UNLESS there is a qualifying event....

- 1) I am covered under another employer medical plan at the date of this certification, and that coverage is lost through termination of employment, change in employment status, termination of the other employer coverage, cessation of the other employer's contribution toward that coverage, death, or divorce; or
- 2) I later become covered under another option of my employer's medical benefit plan, and I wish to change options during an open enrollment period according to my employer's plan terms; or
- 3) A court orders that I provide medical coverage for my dependent.

I understand that I must request enrollment within 30 days of any event listed above in order to be allowed to enroll at that time. I understand that I cannot enroll dependents under any circumstances if I am not enrolled for coverage. I further understand that all the terms and conditions of my employer's insurance benefit plans will apply to my dependents and myself if I apply for coverage.

SIGNATURE:

DATE: