Health Net Dental, Inc. • Health Net Vision, Inc.
Health Net Life Insurance Company

Group Coverage Waiver Statement

Last Name:	First Name: MI:	Social Security Number:
Group Name:		**Group Number:**

Coverage Waived (Please check all that apply):

Indicate plan below:

- ❑ Dental HMO, Health Net Dental
- ❑ Dental PPO, Health Net Life Insurance Company (HNLIC) (Administered by Health Net Dental)
- ❑ Indemnity Dental Plan, Health Net Life Insurance Company (Administered by Health Net Dental)
- ❑ Indemnity Orthodontic Rider, Health Net Life Insurance Company (Administered by Health Net Dental)
- ❑ Managed Vision, Health Net Vision
- ❑ Vision PPO, Health Net Life Insurance Company (Administered by Health Net Vision)
- ❑ Indemnity Vision, Health Net Life Insurance Company (Administered by Health Net Vision)
- ❑ Materials Only, Health Net Vision and Health Net Life Insurance Company (Administered by Health Net Vision)

I have been given the opportunity to enroll in the group employee benefit plan my employer has obtained from Health Net Dental/Health Net Vision/ HNLIC. After consideration, I have decided to waive coverage for:

❑ Myself (No dependent coverage) ❑ Myself and all dependents ❑ My spouse ❑ My dependent child(ren)

Reason for Waiver: (check one)

❑ I am declining coverage because I am covered under another dental or vision benefit plan not affiliated with my current employer. This coverage is provided through:

❑ Military ❑ COBRA or CalCOBRA

❑ Medicare/Medicaid ❑ Individual Policy

❑ My Spouse's Employer Plan - Employer's Name _____

❑ Other (Please indicate) _____

Other Insurance Carrier's Name _____

❑ **Coverage is being declined for my spouse because he/she is covered under another dental or vision benefit plan.**

Insurance Carrier's Name _____

❑ **Coverage for my child(ren) is being declined because they are covered under another dental or vision benefit plan.**

List Names _____

Insurance Carrier's Name _____

❑ **Coverage is being declined for my spouse and/or child(ren).** They are not covered under another dental or vision benefit plan.

List Names _____

I understand that if I later decide to apply for coverage for myself or any dependent(s) for which I am waiving coverage at this time, I and my dependent(s) will not be eligible to enroll until the Employer's next Open Enrollment period. This usually occurs at least once a year at a time determined by the Employer. Coverage will begin after the Open Enrollment period on the effective date established by the Employer. I also understand that at the time of my subsequent application for coverage, I will have to comply with the applicable Group Agreement, Evidence of Coverage, Policy or Certificate requirements for eligibility and enrollment.

This waiver condition will not apply if:

1. (a) you or your waiving dependent(s) were covered under another dental or vision benefit plan at the time of waiver; and
   (b) you execute this form at the time of waiver; and
   (c) you have lost coverage as a result of termination of employment, change in employment status, or death of the individual through which the waiving individual was covered as a dependent; termination of the other plan's coverage; cessation of an employer's contribution; or divorce; and
   (d) you request enrollment within 30 days of loss of other coverage or employer contribution; or
2. The individual elects a different plan during an open enrollment period; or
3. A court orders the coverage of a spouse or minor child, and a request for enrollment is made within 30 days of the issuance of the order.

Employee's Signature Date Spouse's Signature Date