Employee's Name Printed: _____
Email Address: _____
Work Location: _____
Schools please select: **K-8** **OR** **9-12**

SOUTHERN CALIFORNIA CONFERENCE
OF SEVENTH-DAY ADVENTISTS

EMPLOYEE DECLINATION OF
SCC Health Care Coverage
JANUARY 1 –DECEMBER 31, 2019

I, _____ (printed name of employee), understand that participation in the Southern California Conference of Seventh-day Adventists (SCC) health care assistance plan has been offered to me as an employee benefit.

I currently have credible health coverage as follows and will provide reasonable verification of this coverage to the SCC Human Resources Department with a copy of my healthcare card:

_____ _____
Name of other health coverage provider Policy or group number

I expressly reject the coverage offered to me and understand that as of January 1, 2018, I will not have health care benefits (including medical, chiropractic, dental, vision, mental health, and hearing) provided under the SCC Health Care Assistance Plan policy. I may "buy-in" to the dental and vision (DV) plan and will complete a separate application form for the DV plan.

I understand that if I decline health care coverage, my spouse and child(ren) are ineligible for coverage. My spouse, child(ren) and I will not be able to join the SCC health care plan until the next open enrollment period in December, 2019, unless there is a qualifying event, e.g., involuntary loss of current coverage.

I understand that if any health care benefits have been accessed by me or my dependents after the effective date of this declination, I will be responsible for all costs including reimbursing SCC or its insurers for benefits, costs or expenses of services provided after the effective date of this declination and paid on my behalf by SCC or its insurers.

I have signed this rejection without coercion, and no representations or promises have been made regarding health benefits. SCC will provide **$100 per month (which is taxable)**.

I have also completed the necessary Blue Shield declination forms.

By signing this form, I reject the health care coverage offered by SCC as of January 1, 2019. I have had the opportunity to ask questions and have received the information I need.

_____ _____
Signature If married, spouse's signature required

_____ _____
Name printed Date Name of spouse printed Date