



Employee's Name Printed: \_\_\_\_\_

Emails 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  
DENTAL/VISION BUY-IN  
JANUARY 1 –DECEMBER 31, 2019**

I 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 insurance 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, 2019, 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 (D/V) plan and will complete a separate application form for the D/V 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 enrolment 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)**.

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. **However, I choose to BUY-INTO the DENTAL/VISION COVERAGE.**

\_\_\_\_\_  
Signature and last four digits of SSN

\_\_\_\_\_  
If married, spouse's signature required

\_\_\_\_\_  
Name printed

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of spouse printed

\_\_\_\_\_  
Date