California Small Manufacturing Health & Welfare Trust
Declination of Coverage

COMPANY NAME:	**DATE OF HIRE**:

NOTICE OF CERTIFICATION OF COVERAGE DECLINATION. Must be completed if an eligible employee and/or family member declines coverage in the medical plans offered by the California Small Manufacturing Health & Welfare Trust Fund ("Plan").

I decline coverage for:	**FIRST, MIDDLE, LAST NAME**	**SSN**	**DATE OF BIRTH**	Check if **Declining** Coverage
Employee	_____	_____	_____	☐
Spouse	_____	_____	_____	☐
Child	_____	_____	_____	☐
Child	_____	_____	_____	☐
Child	_____	_____	_____	☐

I understand that in the event I and/or my eligible dependents choose to enroll in the Plan at a later date, that we may be considered "Late Enrollees" and may have to wait for coverage for a period of twelve (12) months after the date we enroll.

I have been informed that under the three following circumstances, I and my eligible dependents will not be considered Late Enrollees, and thus, will not have to wait for a period of twelve (12) months after we enroll in the Plan:

1. OTHER EMPLOYER HEALTH BENEFIT PLAN COVERAGE. You and your dependents (collectively "You") shall not be considered Late Enrollees if:

   a. You are covered under another employer health benefit plan ("Plan") although You are also eligible to enroll in the Plan;

   b. You certify, in writing, on the Declination of Coverage that You are declining Plan coverage because You are already covered under another group Plan;

   c. You learn at a later date that You have lost or will lose coverage under the other Plan because of: (1) the termination of your employment or the employment of the person through whom You are covered as a dependent; (2) a change in your employment status or the employment status of the person through whom You are covered as a dependent; (3) the termination of coverage under the other Plan; (4) the termination of an employer's monetary contribution toward your coverage under the other Plan; (5) the death of the person through whom You are covered as a dependent; or (6) the divorce from the person through whom You are covered as a dependent, and

   d. You request enrollment within thirty (30) days after termination of your coverage under the other Plan due to the reasons stated above in Subsection 1(c).

   If you meet each of the requirements listed above, You will not be classified as a Late Enrollee, and will not have to wait twelve (12) months after You enroll.

2. MULTIPLE PLANS. If your employer offers one or more other Plans and You enrolled in one of such Plans during an open enrollment period, You will not be classified as a Late Enrollee if You enroll at a later open enrollment date.

3. COURT ORDER. If a court has ordered that You obtain health care coverage for your spouse or minor child, and You submit an application for enrollment within thirty (30) days after issuance of the court order, you and your spouse and/or minor child will not be classified as Late Enrollees.

I CERTIFY THAT THE REASON I AM DECLINING ENROLLMENT IS: (Check one)

☐ I am covered under another group health benefit plan offered to my spouse.

☐ I am covered under another group health benefit plan offered by my EMPLOYER.

X _____ _____
Signature Date (Mo/Day/Year)

If declining coverage for employee/dependent(s), please sign here.