# MONMOUTH UNIVERSITY

OFFICE OF HUMAN RESOURCES

## MEMBER DECLINATION OF COVERAGE

**EMPLOYEE NAME:** _____
(please print)

**SOCIAL SECURITY #** _____

**THIS FORM MUST BE COMPLETED AND SIGNED BY EACH EMPLOYEE WHO IS A NEW ENROLLEE INTO THE VOLUNTARY MEDICAL FINANCIAL INCENTIVE PROGRAM.**

I UNDERSTAND THE OPTIONS AVAILABLE TO ME AS EXPLAINED IN THE ACCOMPANYING REVISED POLICY STATEMENT. I HAVE INDICATED MY CHOICE BELOW.

- ❑ I am currently eligible for **Family** coverage in a Monmouth University Medical Program and I elect to decline ALL coverage. My dependents and I are insured with the health insurance program listed below.

- ❑ I am currently eligible for **Family** coverage in a Monmouth University Medical Program and I elect to decline ALL DEPENDENT coverage and retain SINGLE coverage. My dependents are insured with the health insurance program listed below.

- ❑ I am currently eligible for **Family** coverage in a Monmouth University Medical Program and I elect to decline my SPOUSE'S/PARTNER'S coverage and retain PARENT/CHILD coverage. My spouse/partner is insured with the health insurance program listed below.

- ❑ I am currently eligible for **Family** coverage in a Monmouth University Medical Program and I elect to decline ALL DEPENDENT CHILDREN'S coverage and retain EMPLOYEE plus SPOUSE/PARTNER coverage. My child/children is/are insured with the health insurance program listed below.

- ❑ I am currently eligible for **Parent/Child** or **Employee/Spouse or Employee/Partner** coverage in a Monmouth University Medical Program and I elect to decline ALL coverage. My dependents and I are insured with the health insurance program listed below.

- ❑ I am currently eligible for **Parent/Child** or **Employee/Spouse or Employee/Partner** coverage in a Monmouth University Medical Program and I elect to decline ALL DEPENDENT coverage and retain SINGLE coverage. My dependents are insured with the health insurance program listed below.

- ❑ I am currently eligible for **Single** coverage in a Monmouth University Medical Program and I elect to decline ALL my coverage. I am insured with the health insurance program listed below.

I am declining medical coverage as indicated above because medical coverage is provided to me and/or my dependents through (insured's name) _____, whose social security number is _____. This insurance is provided through

(insured employer's name) _____, and the name and policy number of the insurance company is _____.

**I understand that if I decline coverage through Monmouth University at this time, and I lose my "alternate" medical coverage as a result of loss of employment or another qualifying event occurs as defined by the Internal Revenue Code, I must notify the Office of Human Resources immediately in writing. I must also complete a group insurance application and submit it to the Office of Human Resources within 30 days of the date the qualifying event occurs, and must provide written proof that I/we are no longer eligible for the insurance identified above. I must reimburse to Monmouth University monies overpaid, if any, via the Voluntary Financial Incentive Program. Furthermore, I understand that my insurance as an employee of Monmouth University will become effective the first of the following month following the date of the qualifying event provided that I have complied with the aforementioned conditions, and I will agree to refund the University for any premiums due and unpaid for this period of coverage.**

**I further understand that if I decline coverage at this time, I will not be eligible to re-enroll until an open enrollment period, unless an involuntary event as noted above occurs which results in my being ineligible for the "alternate" group insurance.**

_____ EMPLOYEE NAME (please print)

_____ EMPLOYEE SIGNATURE

_____ DATE

List all eligible dependents you are waiving under the medical plan (spouse, civil union partner and children under the age of 26):

| NAME | RELATIONSHIP | DATE OF BIRTH | SOCIAL SECURITY NO. |
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**FOR OFFICE OF HUMAN RESOURCES USE ONLY:**

EFFECTIVE DATE OF DECLINE: _____

FINANCIAL INCENTIVE AMOUNT: _____

MANAGER OF EMPLOYEE BENEFITS: _____

CC: Employee File
Voluntary Financial Incentive File