Newport-Mesa
Unified School District

BENEFITS MANAGEMENT
nmusd.us/benefits
benefitsmanagement@nmusd.us

HEALTH COVERAGE DECLINATION
2023-2024

If you are eligible for health coverage for you and/or your dependent(s) under the N-MUSD group health plans and you wish to decline to enroll in this coverage, you **must** complete this form.

PLEASE READ AND COMPLETE THIS FORM VERY CAREFULLY!
I am declining to enroll in the following health benefit coverage:
(Please check all that apply)

	Medical Plan **(Do not want coverage)**
	Dental Plan **(Do not want coverage)**
	Vision **(Do not want coverage)**
	Check one **___Certificated ___Classified**

I am declining enrollment for **_____ - 9/30/2024** under my employer's health benefit plan for the reasons indicated below:

A. _____ Coverage under another Employer's Health Benefit Plan.

Employer Name: _____ Effective Date of Coverage: _____

Name of Other Coverage: _____ Group Number: _____

B. _____ Enrolled in Covered CA / Health Care Exchange

C. _____ Other Reason _____

I have read the above and acknowledge that I have been given the opportunity to enroll myself and, if applicable, my eligible dependents. I have chosen ***not to enroll*** in the benefits checked above. I also acknowledge receipt of this Notice and understand that I will not be eligible to enroll until the next Open Enrollment period.

Signature (Employee): _____ **Print Name:** _____

Address: _____