

HEALTH COVERAGE DECLINATION 2026-2027

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 _____ - **9/30/2027** 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: _____