Turlock Unified School District

Finance & Accountability

EMPLOYEE HEALTH PLAN
DECLINATION OF COVERAGE FORM

COMPLETE ONLY IF YOU ARE **DECLINING THE MEDICAL COVERAGE** OFFERED BY TUSD FOR THE **2027** CALENDAR YEAR. THIS FORM DOES NOT CANCEL ANY CURRENT MEDICAL COVERAGE WITH TUSD.

EMPLOYEE NAME (PRINT): (FIRST) (INITIAL) (LAST)	LAST 4 DIGITS OF SSN:

I DECLINE TO ENROLL IN THE MEDICAL COVERAGE OFFERED FOR MYSELF AND MY ELIGIBLE DEPENDENTS. IN DECLINING SUCH COVERAGE, I UNDERSTAND THAT:

_____ I am declining coverage for myself and my eligible dependents.
Initial

_____ By declining coverage, I understand that I/we will not be eligible to enroll for such coverage under the plan(s)
Initial until the next open enrollment period, unless I meet the criteria stated below for a Special Enrollment exception.

_____ If one of the Special Enrollment exceptions below applies, I understand that my eligible dependents and/or I
Initial will be considered eligible to enroll during the plan year, subject to the timelines stated in the exceptions and I will not have to wait for the next open enrollment period to obtain coverage under the plan(s).

SPECIAL ENROLLMENT Special Enrollment is a period of time allowed under this Plan, other than the eligible person's Initial Enrollment Period or an Open Enrollment Period, during which an eligible person can request coverage as a result of certain events that create special enrollment rights. Special enrollment events include the involuntary loss of other group health plan coverage. Also, in the event of marriage, birth, adoption or placement for adoption, you may enroll yourself and your newly acquired spouse and/or children for coverage. Coverage will become effective the following month of when the application for such coverage is received by the District Office. The application must be received within thirty-one (31) days of the event.

You or your eligible dependents may also have special enrollment rights in this Plan as a result of the loss of eligibility for coverage or becoming eligible for a premium subsidy under Medicaid or a state sponsored Children's Health Insurance Program (CHIP). A request for enrollment must be submitted to the district office within sixty (60) days of loss of such coverage or the date of the Determination Letter advising of the eligibility for premium subsidy issued by either Medicaid or CHIP. You should consult with your local Medicaid or CHIP office regarding rights to the premium subsidy.

HIPAA PRIVACY Turlock Unified School District is fully compliant with the privacy provisions of the Health Insurance Portability and Accountability Act of 1996.

EMPLOYEE SIGNATURE: _____ **DATE:**_____

1574 E. Canal Drive, PO Box 819013 • Turlock, CA 95381-9013 Ph 350.206.3900 Ext. 62931 Fax (209) 669-6457