CUESTA COLLEGE

DECLINATION OF COVERAGE FOR LESS THAN FULL-TIME ACTIVE EMPLOYEES AND HIPAA NOTIFICAITON

If you work less than full-time and receive less than the amount that is contributed towards a full-time employee, you may decline coverage. If you decline coverage, you and your dependents will not be allowed to enroll until the Open Enrollment Period. Members who enroll during the Open Enrollment Period will become effective October 1, of the same year.

If you decline coverage and subsequently become a full-time employee or begin receiving the same contribution as a full-time employee, you must enroll in the plan the first of the month following the date of this event. If the number of hours worked increases or payment of coverage by San Luis Obispo Community College District increases, you may choose to enroll the first of the month following the date of that occurrence.

If you are declining for you or your dependents (including your spouse) because you and/or your dependents have coverage elsewhere and you subsequently lose coverage, you may enroll yourself or your dependents immediately provided you notify the district within 30 day of loss of coverage. You must submit a completed and signed enrollment or change form along with a copy of the Certificate of Coverage from the "coverage elsewhere" or evidence of loss of coverage elsewhere.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, or placed in your home as a result of court ordered custody or guardianship, you may enroll yourself and your dependents, provided that you request enrollment within 30 days following the date of this event.

If you fail to notify your employer that your dependents(s) are no longer eligible for coverage under your plan, they may not be eligible for continuation coverage under the COBRA or CalCOBRA law.

I have read and understand the above notification. I understand that, if I decline coverage, I will not be able to enroll in coverage until the district's Open Enrollment period for an October 1 effective date or because of one or more of the events listed above.

I am declining health care coverage under San Luis Obispo Community College District due to the following reason(s).

_____

_____

_____

Print Name: _____

Signature: _____ Date: _____

Last 4 Digits of Social Security Number: _____

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