Waiver of Medical Coverage

NOTE: CAPITALIZED WORDS HAVE THE SAME DEFINITIONS AS IN CERTIFICATE OF COVERAGE

By signing below, I acknowledge that health coverage offered by FirstCarolinaCare Insurance Company, Inc. (FCCIC) has been made available and explained to me. I have been given the opportunity to enroll myself and my Dependents in the available coverage, but I have elected to decline such coverage.

I understand that if I decline Enrollment now, I may only enroll at the next annual Enrollment period, *unless* eligible for Special Enrollment. If I or my Dependents are not Special Enrollees* and enroll any time after the initial Open Enrollment Period, we will be considered Late Enrollees. Late Enrollees are subject to an eighteen (18) month Pre-Existing Conditions Exclusion period.

Please Select a Reason For Declining Coverage:

1. ☐ I currently am covered under another group health plan or other health coverage, and such coverage is the reason for declining Enrollment with FCCIC.
2. ☐ I am currently enrolled in COBRA Continuation Coverage.
3. ☐ Other: _____

* If you are declining Enrollment for yourself or your Dependents **because of other health coverage (reason #1 or #2)**, you may enroll as Special Enrollees if you lose your other coverage, provided that you request Enrollment within thirty-one (31) days after your other coverage ends. In addition, if you have a new Dependent as a result of marriage, birth, adoption or placement for adoption or Foster Care, you may be able to enroll yourself and your Dependents, provided that you request Enrollment within thirty-one (31) days after the marriage, birth, adoption or placement for adoption or Foster Care.

Important Note to Employer: If the Eligible Employee is declining Enrollment due to Enrollment in other health coverage, please obtain a copy of the Eligible Employee's health plan Identification Card or other proof of coverage and attach to this form.

Employer Name: _____

Coverage Effective Date: _____

Employee Name: _____
(Print)

Social Security Number: _____

Employee Signature: _____ Date: _____