Southeastern California Conference

of Seventh-day Adventists
11330 Pierce Street, P.O. Box 79990
Riverside, CA 92513
(951) 509-2352

HEALTH CARE BENEFITS SUBSCRIBER OPT OUT FORM

Employee: ______________________________
SS# ***(last 4 numbers only)*****:** ______________________________
Effective: ______________________________

___ I understand that I am eligible for Southeastern California Conference (SECC) healthcare benefits but have alternative healthcare coverage and hereby request to "opt out" of all Adventist Risk Management-Healthscope/Kaiser/Delta Dental and HCAP benefits in exchange for a payment of $150.00 per month. By signing this form, I hereby (1) decline SECC coverage; and (2) certify that I have health plan or health insurance coverage from another source, such as a health plan sponsored by the employer of my spouse or parent, or a federal plan, such as Medicare or Medicaid. Attached is documentation showing proof of coverage.

By declining coverage for myself as an employee, I understand that my spouse and dependent children are not eligible for SECC coverage. I understand that my ability to enroll myself and my dependents at a later date may be restricted to certain time periods, such as (1) an open enrollment period of my employer; and/or (2) the special enrollment periods described in the Plan.

I also acknowledge, I have been advised that I may not qualify: (1) Since I am eligible for SECC coverage, my tax dependents and I will not qualify for any federal subsidy (premium tax credit) available for health insurance purchased at a Health Insurance Marketplace (for more information about the Health Insurance Marketplaces, visit www.healthcare.gov); (2) I am signing this form voluntarily and I am not required by my employer to sign this form.

___ I am eligible for SECC healthcare benefits but have alternative medical coverage and hereby request to "opt out" of all Adventist Risk Management--Healthscope/Kaiser coverage. I wish to receive Delta Dental and/or vision (HCAP) benefits provided by SECC. I understand that I do not receive a payment of $150.00 per month by electing Delta Dental and/or HCAP. Attached is documentation showing proof of coverage from another source as described above.

Spouse's name:	________________________	DOB: ________	❑Delta Dental	❑HCAP
Children(s) name:	________________________	DOB: ________	❑Delta Dental	❑HCAP
	________________________	DOB: ________	❑Delta Dental	❑HCAP
	________________________	DOB: ________	❑Delta Dental	❑HCAP
	________________________	DOB: ________	❑Delta Dental	❑HCAP

Employee's Signature:_______________________ Date: ____________________