Waiver of Group Health Benefits
拒絕參加公司醫療保障

Group Name 公司團體名稱： _____

Group Number 公司團體號碼： _____

Employee Name 僱員名稱 (Last 姓, First 名, M.I. 中間名): _____

I am declining coverage for myself and dependents due to 本人拒絕為自己及家屬投保之原因：

[ ] Covered by spouse's/domestic partner's group plan 本人已投保配偶/家庭伴侶的公司醫療計劃

Name of carrier 承保機構名稱: _____

[ ] Covered by individual policy 已有個人醫療保險計劃

Name of carrier 承保機構名稱: _____

[ ] Covered by Medicare 已有聯邦醫療保險

[ ] Covered by Medi-Cal 已有加州醫療保健 (白卡)

[ ] Other coverage 其它保障 - Name of carrier 承保機構名稱: _____

[ ] My preference not to have coverage 本人不需要醫療保障

My employer had thoroughly explained the group health insurance plan to me and I decline to participate. I understand that I cannot change my election until the next open enrollment period or until I experience a qualifying change in status that would allow me to change my election. I must request enrollment within 30 days of such change. 本人的僱主已向我詳細解釋團體醫療保險計劃及本人拒絕投保。本人明白直至下一個開放登記期前，或遇到合資格的特別情況前都不可改變選擇。本人必須在遇到這種變化的 30 日內申請投保。

- Marriage or divorce 結婚或離婚
- Spouse terminates employment 配偶失業
- Birth or adoption of a child 新生嬰兒或收養子女
- Death of a spouse or child 配偶或子女死亡
- Full-time to part-time change (or vice versa) 全職兼職改變

Signature of Employee 僱員簽署： _____

Date of Signature 簽署日期： _____

Please return a copy to human resources department 請將此文件交回人事部