# 2012
# Declination of Coverage

Name of Employee ________________________________ Social Security Number______________________

| **Employer Name:** | | |
|---|---|---|
| ☐Samaritan Albany General Hospital | ☐FirstCare Physicians | ☐FirstCare Health Foundation |
| ☐Samaritan North Lincoln Hospital | ☐Samaritan Resources | ☐Samaritan Health Physicians (MVMG) |
| ☐Samaritan Pacific Communities Hospital | ☐Samarltan Endoscopy Ctr | ☐Samaritan Health Physicians (SMG) |
| ☐Good Samaritan Regional Medical Center | ☐SHS Corporate | ☐Samaritan Lebanon Community /Wiley Creek Community |

## Please Check Appropriate Boxes

I hereby acknowledge that I have been offered group coverage under my employer's health plan and I have declined coverage for:

- ☐ Myself
  - ☐ Medical Coverage (Samaritan Choice Plans)
  - ☐ Dental/Vision Coverage (ODS/Samaritan Choice Plans)
- ☐ Myself and my eligible family members
  - ☐ Medical Coverage (Samaritan Choice Plans)
  - ☐ Dental/Vision Coverage (ODS/Samaritan Choice Plans)

Coverage has been declined because I and/or my family members:

1. ☐ Do not wish coverage and do not have other medical or dental/vision coverage.

2. ☐ Do have other group health coverage through my spouse's employer.
   - ☐ Medical Coverage
   - ☐ Dental/Vision Coverage

   **Under TRICARE's prohibition (01/01/08) on incentives, an employer may not provide financial or other incentives for a TRICARE-eligible employee not to enroll (or to terminate enrollment) under a group health plan that would be a primary plan. This TRICARE rule mimics the existing Medicare Secondary Payer (MSP) rules prohibiting financial or other incentives, and each violation of the TRICARE rule can trigger a civil penalty of up to $5,000.**

3. ☐ Do have individual medical coverage
4. ☐ Do have Medicare coverage
5. ☐ Do have other type of coverage

If you have checked Number 2, 3, 4, or 5 above, please complete the Coverage Information section below.

## Coverage Information

| Policy Number | ID Number |
|---|---|
| Name of Insurance Company | Name of Spouse's Employer |

I hereby decline coverage in the benefit plan offered by my employer because I have existing coverage under another group plan or a policy issued by the Insurance Pool Governing Board. I understand that if my existing coverage is lost due to termination of employment, termination of the health plan, death of my spouse, or divorce, I must enroll in my employer's plan within 30 days or my coverage will be subject to waiting periods of up to 12 months.

______________________________________ ______________________________________

Employee Signature Date

11-02-11