

## Benton County Insurance Refusal Form

I hereby acknowledge that I have been offered group coverage under Benton County's medical, dental, and group life insurance plans.

I hereby **decline** Benton County's **Medical Insurance** for the following eligible persons:

- Myself       My Spouse       My Dependent Children

My reason for declining coverage is due to: \_\_\_\_\_

- Other Group Insurance     Other (please describe): \_\_\_\_\_
- 1). Name of Company: \_\_\_\_\_ 2). Insurance Carrier: \_\_\_\_\_
- 3). Group Policy #: \_\_\_\_\_ 4). Individual ID #: \_\_\_\_\_

I understand that since I have refused, I am not eligible for the County's medical insurance except as outlined in the insurance carrier contract. **IF YOU ARE DECLINING MEDICAL COVERAGE, YOU WILL ALSO NEED TO COMPLETE THE PACIFICSOURCE WAIVER OF HEALTH INSURANCE COVERAGE (SEE BACK OF THIS FORM)**

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I hereby **decline** Benton County's **Dental Insurance** for the following eligible persons:

- Myself       My Spouse       My Dependent Children

My reason for declining coverage is due to: \_\_\_\_\_

- Other Group Insurance     Other (please describe): \_\_\_\_\_
- 1). Name of Company: \_\_\_\_\_ 2). Insurance Carrier: \_\_\_\_\_
- 3). Group Policy #: \_\_\_\_\_ 4). Individual ID #: \_\_\_\_\_

I understand that since I have refused, I am not eligible for the County's dental insurance except as outlined in the insurance carrier contract.

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As a part-time employee, I elect not to participate in Group Life and AD&D Insurance. I understand that by declining Group Life and AD&D coverage, that my future application will be subject to evidence of insurability satisfactory to the life insurance company. I also understand that if I am employed in a full-time position, that I will have another opportunity to enroll at that time without evidence of insurability. \_\_\_\_\_ (Initials)

I understand that on the basis of the boxes I have marked, enrollment in my employers group insurance plan(s) will not be available until a later date which is acceptable to both my employer and to the insurance carrier which will require evidence of insurability in some situations.

\_\_\_\_\_  
Employee Name (please print)

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Payroll - Receipt Date & Initials