NORTH CAROLINA BAR ASSOCIATION
HEALTH BENEFIT TRUST

Declination of Coverage

TO BE COMPLETED BY GROUP ADMINISTRATOR ONLY	GROUP NUMBER	EFFECTIVE DATE

EMPLOYEE NAME LAST	FIRST	MIDDLE
SOCIAL SECURITY NUMBER	DATE OF FULL-TIME EMPLOYMENT	DATE OF BIRTH
FIRM NAME		
FIRM ADDRESS		

CHECK ONE ONLY: ☐ I am rejecting Employee Coverage ☐ I am rejecting Dependent/Spouse Coverage

I certify that I have been given the opportunity to participate in the group health plan offered by my employer and have declined to participate. I have declined to participate for the following reason (check one):

☐ Another plan offered by my employer
☐ An individual plan
☐ COBRA or State Continuation
☐ My spouse's group coverage
☐ A government plan (type)
☐ I and/or my dependents are currently not covered by any other health benefit plan

☐ Other (explain): _____

Names of any dependents rejecting coverage for this group plan:

_____

_____

Signature of Employee _____ Date _____

Notice of Declination of Coverage must be received by Blue Cross and Blue Shield of North Carolina within 30 days of the date that employee is first eligible for coverage.