600 N. Grand Avenue, Los Angeles, CA 90012 | Tel (213) 674-3701 or (888) 252-7721 | Fax (213) 674-3715 | www.lapra.org

# Medical & Dental Declination Form

RESET ALL FORM FIELDS

## Medical & Dental Plans Offered by the Los Angeles Police Relief Association, Inc.

- Blue Cross of California – Prudent Buyer Plan
- Blue Cross of California – California Care Plus Plan
- Kaiser Foundation Health Plan, Inc.
- Blue Cross Dental PPO
- Blue Cross Dental HMO

## Member's Personal Information

| Last Name | First Name, MI | Social Security Number | Birth Date |
|---|---|---|---|
| | | | |

| Street Address | Unit # | City | State | Zip Code | Phone Number |
|---|---|---|---|---|---|
| | | | | | |

## Medical & Dental Declination

I hereby decline coverage offered by the Los Angeles Police Relief Association, Inc.(LAPRA) for the persons and plans as I have indicated below:

**Myself**
☐ Medical
☐ Dental

☐ I am covered under another medical and/or dental plan.

☐ I am not covered under another medical and/or dental plan, but I do not choose to enroll at this time.

**Spouse / Domestic Partner**
☐ Medical
☐ Dental

Name: _____
SSN: _____
Address: _____
_____

☐ He/she is covered under another medical and/dental plan.
☐ He/she is not covered under another medical and/or dental plan, but I do not choose to enroll at this time.
☐ I am legally divorced from this person effective: _____
☐ I am no longer living together with my Domestic Partner

**Child**
☐ Medical
☐ Dental

Name: _____
SSN: _____

☐ He/she is covered under another medical and/or dental plan.
☐ He/she is not covered under another medical and/or dental plan, but I do not choose to enroll at this time.

**Child**
☐ Medical
☐ Dental

Name: _____
SSN: _____

☐ He/she is covered under another medical and/or dental plan.
☐ He/she is under another medical and/or dental plan, but I do not choose to enroll at this time.

## Member Signature & Disclaimer

I, the undersigned, understand that I'm declining coverage at this time for the individuals identified above. I understand that If I am declining coverage for myself or my dependents (including spouse/domestic partner) because of other health insurance coverage, I may in the future be able to enroll myself or my dependents in a LAPRA medical and/or dental plan provided that I request enrollment within 31days after (i) the other coverage ends or (ii) an employer ceases contributing to that other coverage. In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption I may be able to enroll myself and my eligible dependents, provided I do so within 31days after marriage, birth, adoption or placement for adoption. Even if I do not complete and return this form to LAPRA within the required time, I will be deemed to have declined medical and/or dental coverage for myself and my eligible dependents if I have not properly enrolled in such medical and/or dental coverage on a timely basis. I release LAPRA and its Board members, employees, officers, directors and agents from any liability arising out of, or relating to, any declination of coverage.

**City of Los Angeles - FEDERAL LAW P.L. 93-579 Section 7** re: Federal Privacy Act and Use of Social Security Numbers. This law requires you be informed when asked for your Social Security Number, that it must be provided for use in employment, personnel and payroll processes. Authority for requiring this information is based upon provisions of the City's payroll and personnel candidate processing system operational prior to January 1, 1975 and applicable Federal Law.

OFFICE USE ONLY

Please discontinue deductions from salaries payable to me by the City of Los Angeles for Code No: _____.

| Date | Signature |
|---|---|
| | |

0567 Med Dent Dec Form