



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

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
- Anthem HMO Medicare Advantage Plan
- Blue Cross Dental PPO
- Blue Cross Dental HMO
- Kaiser Foundation Health Plan, Inc.

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 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.
 Dental

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

Child
 Medical Name: _____ He/she is covered under another medical and/or dental plan.
 Dental SSN: _____ He/she is not covered under another medical and/or dental plan, but I do not choose to enroll at this time.

Child
 Medical Name: _____ He/she is covered under another medical and/or dental plan.
 Dental SSN: _____ 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