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www.culinaryhealthfund.org

ELECTIVE DISENROLLMENT FORM
WAIVER OF COVERAGE

MEDICAL – DENTAL – VISION – LIFE INSURANCE – PRESCRIPTION

The purpose of this form is to electively disenroll your eligible dependent(s) from the Culinary Health Fund Plan effective the first day of the month immediately following the date this form is completed, submitted and approved by the Culinary Health Fund or its designee.

Section A: PARTICIPANT INFORMATION

Last Name	First Name	Middle Int.	Birth Date	Social Security No.	Sex
					M ☐ F ☐

Address	City	State	Zip

Home Phone Number	E-mail Address:	Language Preference: ☐ English ☐ Spanish ☐Other: ________

Section B: LIST BELOW THE DEPENDENT YOU ARE ELECTING TO DISENROLL

Last Name	First Name	Date of Birth	Sex	Other Health Care Coverage Name & Policy Number	Relationship to Participant

Section C: PLEASE PROVIDE REASON FOR DISENROLLMENT REQUEST:

Section D: HIPAA SPECIAL ENROLLMENT RIGHTS

If you electively disenroll your dependent from the Plan, and wish to re-enroll them at a later date, you will have to wait 30 days from the date that you disenrolled them. Your dependent will be eligible the 1st of the following month of the re-enrollment. Your dependent may also be re-enrolled in the Culinary Health Plan when they experience a qualifying event (such as loss of other health coverage due to termination of employment, change in employment status, etc.) whichever is first.

If a qualifying event occurs, that dependent will be required to provide the Culinary Health Fund with a copy of the "HIPAA Certificate Of Creditable Coverage" within 30 days from the loss of other health coverage before your dependent is allowed to enroll back into the Plan. Please read the attached HIPAA Special Enrollment Rights and keep a copy for your records.

Section E: PLEASE READ CAREFULLY AND SIGN BELOW

- **I understand that by electively disenrolling my dependent from the Plan, they will not be eligible to receive benefits from the Culinary Health Fund Plan effective the first day of the month immediately following the date this form is submitted and approved by the Culinary Health Fund or its designee. This means your dependent will no longer be covered under the plans listed below. You must write your initials by each plan to acknowledge you understand.**
- **Medical _____ (initials), Prescription Drug ______ (initials), Dental ______ (initials), Life Insurance______ (initials)**
- **I certify that I am not subject to any court order or decree (QMCSO, etc.) which restrict my right to decline health coverage for my dependent(s).**
- **I confirm that I have read and understand the attached HIPAA Special Enrollment Rights.**
- **I certify that the information I have provided herein on the Elective Disenrollment form is true and correct.**

______________________________ ______________________
Employee Signature Date

______________________________ ______________________
Dependent Signature Date

State of Nevada, County of Clark
This instrument was acknowledge before me on: ____________ day of ____________________ 20______

____
Notary Signature