DECLINATION OF MEDICAL COVERAGE

I _____
hereby decline medical coverage. I realize that I must provide documentation that I currently have medical coverage provided by:

_____
EMPLOYER

_____
CARRIER

_____
CONTRACT NUMBER

I understand that if the medical coverage provided by _____ should terminate or change, I must notify the Human Resources Department within 31 days of loss of other coverage if I intend to enroll in the MCC medical coverage. This medical coverage will be available to me and my eligible dependent(s) regardless of any pre-existing condition.

_____
EMPLOYEE'S SIGNATURE

_____
DATE

_____
PRINT NAME