**LOS ANGELES POLICE RELIEF ASSOCIATION, INC.**

600 N. GRAND AVENUE, LOS ANGELES, CA 90012-2212 • (213) 674-3701 • (888) 252-7721 • FAX (213) 674-3715 • www.lapra.org

# MEDICAL DECLINATION FORM

**Medical Coverage 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.

I hereby decline medical coverage offered by the Los Angeles Police Relief Association, Inc. for the following persons:

*Fill out a statement for each individual eligible for coverage, but for whom you are declining coverage*

| Self: | SSN: |
|---|---|

Check Reasons:
- ❑ I am covered under another medical plan
- ❑ I am not covered under another medical plan, but do not choose to enroll at this time

| Spouse/Domestic Partner Name: | SSN: |
|---|---|

Check Reason:
- ❑ I am covered under another medical plan
- ❑ I am not covered under another medical plan, but do not choose to enroll at this time
- ❑ I am legally divorced from this person

| Child: | SSN: |
|---|---|

Check Reason:
- ❑ I am covered under another medical plan.
- ❑ I am not covered under another medical plan, but do not choose to enroll at this time.
- ❑ This dependent is not a full time student and/or is over age 25.

| Child: | SSN: |
|---|---|

Check Reason:
- ❑ I am covered under another medical plan
- ❑ I am not covered under another medical plan, but do not choose to enroll at this time
- ❑ This dependent is not a full time student and/or is over age 25.

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| Child: | SSN: |
|---|---|

Check Reason:
- ❑ I am covered under another medical plan
- ❑ I am not covered under another medical plan, but do not choose to enroll at this time
- ❑ This dependent is not a full time student and/or is over age 25.

| Child: | SSN: |
|---|---|

Check Reason:
- ❑ I am covered under another medical plan
- ❑ I am not covered under another medical plan, but do not choose to enroll at this time
- ❑ This dependent is not a full time student and/or is over age 25.

| Child: | SSN: |
|---|---|

Check Reason:
- ❑ I am covered under another medical plan
- ❑ I am not covered under another medical plan, but do not choose to enroll at this time
- ❑ This dependent is not a full time student and/or is over age 25.

**I, the undersigned, understand that by declining coverage at this time, if I choose to apply for enrollment at a later date, I may be excluded from coverage for a period of up to 12 months. In addition, once enrolled, I understand that my coverage may be subject to a six-month exclusion for pre-existing conditions.**

"Note: If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan provided that you request enrollment within 31days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption you may be able to enroll yourself and your dependents, provided within 31days after marriage, birth, adoption or placement for adoption.

| | **For LAPRA Use Only** | |
|---|---|---|
| Member Name (Print or Type) | Group Number(s) | Received & Recorded by |
| Member Signature (Date) | | |