DECLINATION OF HEALTHCARE COVERAGE

Employee Information

Personal Information

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Home Phone: _____ Alternate Phone: _____

Email _____

Employee ID #: _____

The City of New Orleans, offers as a benefit of employment, all employees the opportunity to participate in its healthcare plan. The healthcare plan includes medical, dental and vision coverage through the United Healthcare's network of providers. As a new hire, an existing employee, or re-hired employee, you have the opportunity to enroll yourself and your dependents in this plan. You have a specified time to enroll yourself and dependents either upon hire or during annual Open Enrollment. For enrollment, please see your departmental Human Resource professional.

Should you choose not to enroll, please indicate that you are declining healthcare coverage below:

NEW HIRE DECLINATION OF COVERAGE

☐ I am declining healthcare coverage.

_____ _____
EMPLOYEE NAME DATE

OPEN ENROLLMENT DECLINATION OF COVERAGE:

☐ I am declining healthcare coverage.

☐ I am dropping healthcare coverage for my spouse/domestic partner.

☐ I am dropping healthcare coverage for my dependent child/children.

_____ _____
EMPLOYEE SIGNATURE DATE