STATE OF MARYLAND

DECLINE ALL COVERAGE FORM FOR JANUARY 2018-DECEMBER 2018

Name:		
Address:		FIRST MI Apt/Condo:
		Zip Code:
Home Phone: ()		1
Work Phone: ()		
Cell Phone: ()		Sex: Male Female
Personal E-mail:		Legal Marital Status:
		Single Limited Divorce/Legally Separated
Work E-mail:		Married Divorced Widowed
Social Security Number:///		
Date of Birth: / / / YYYY		
TO BE COMPLETED BY	AGENCY B	ENEFITS COORDINATOR
Active Full-Time Employee		7 - Personal
Entry on Duty Date:	Ef	fective Date: End Date:
Active Part-Time Employee	LAW	- Military
Entry on Duty Date:	Ef	fective Date: End Date:
Satellite Employee	LAW	7 - OJI
Entry on Duty Date:	Ef	fective Date: End Date:
Contractual/Variable Hour Employee State Subsidy Eligible	<u>e</u>	Control Control December 11 11 11 11 11 11 11 11 11 11 11 11 11
Contract Period From:To:		Center: Central Payroll University Satellite
		ncy Code: Check Dist. Code:
Contractual/Variable Hour Employee NO State Subsidy		(if applicable)
Contract Period From: To:		
DECL	INE ALL CO	VERAGE
By signing below, I certify that I have been given an opportunit enrollment. I FURTHER CERTIFY THAT I am declining enrolling insurance or group health plan coverage. I UNDERSTAND The eligible dependents lose, eligibility for THE OTHER HEALTH towards my or my eligible dependents' other coverage.	ty to enroll in coverage for the liment for myself or my of the HAT I may be able to enroll INSURANCE OR GRO	or myself and my eligible dependents, if any. I am declining eligible dependents (including my spouse) because of other health oll myself and my eligible dependents in this plan if I lose, or my UP HEALTH PLAN coverage, or if the employer stops contributing
X	/ X	Agency Benefits Coordinator Signature Date
Employee Signature		
	Work	x Phone#: (
	Fax#	: (
	E-ma	il:

Health benefits information and forms are available on our website: https://pub.maryland.gov/sites/dbm/benefits