Southeastern
California
Conference

of Seventh-day Adventists
11330 Pierce Street, P.O. Box 79990
Riverside, CA 92513
(951) 509-2352

HEALTH CARE BENEFITS SUBSCRIBER OPT OUT FORM

Employee: ______________________________
SS# *(last 4 numbers only)*: ______________________________
Effective: ______________________________

☐ I am covered under a (SECC) Southeastern California Conference **employee** healthcare plan (via spouse or parent), I can't receive the $150 opt-out benefit. If my coverage changes due to personal circumstances or aging out, I'll contact the SECC HR Department to enroll for continued benefits.

☐ I am eligible for SECC healthcare benefits but have alternative coverage. I request to opt out of Adventist Risk Management-Ascend to Wholeness/Kaiser/Delta Dental and HCAP benefits, in exchange for a **monthly payment of $150**. Attached is proof of my medical coverage.
By signing, I (1) decline SECC coverage; and (2) confirm I have health coverage from another source, such as my spouse or parent's employer, or a federal plan like Medicare or Medicaid, with attached proof. By declining coverage, I understand my spouse and dependent children aren't eligible for SECC coverage. I also understand enrollment for myself, and my dependents may be limited to specific periods, like my employer's open enrollment or special enrollment periods described in the Plan.

☐ I acknowledge that my medical coverage is through Medi-Cal, making me ineligible for the $150 opting-out benefit from SECC medical coverage. Additionally, I am not altering my medical coverage with my employer.

☐ I have alternate medical coverage but would like to get Delta Dental and/or vision (HCAP) benefits from SECC. I understand I won't receive the $150.00 monthly payment by opting for Delta Dental and/or HCAP. Attached is proof of medical coverage from another source as requested.
(Eligible for full-time or salary employee)

Spouse's name: ________________________ DOB: ________ ☐ Delta Dental ☐ HCAP
Children(s) name: ________________________ DOB: ________ ☐ Delta Dental ☐ HCAP
________________________ DOB: ________ ☐ Delta Dental ☐ HCAP
________________________ DOB: ________ ☐ Delta Dental ☐ HCAP
________________________ DOB: ________ ☐ Delta Dental ☐ HCAP

Employee's Signature: ________________________ Date: _____________________