AMERICAN TRUST ADMINISTRATORS, INC.
7223 W 95TH ST, OVERLAND PARK, KS 66212
SERVICE ORGANIZATION FOR YOUR EMPLOYER'S PLAN

Employee Refusal Form
For Employees Refusing All Coverage

INSTRUCTIONS FOR COMPLETING THIS FORM

1. This form must be completed by the **EMPLOYEE ONLY.**
2. Please **PRINT** in **BLACK INK** only and **INITIAL & DATE** all corrections.

STEP 1: PLEASE TELL US ABOUT YOURSELF

Last Name	First Name	M.I.

Home Address	City	State	Zip Code

Sex ☐ Male ☐ Female	Social Security Number – –	Birthdate / /	Hours worked per week:
What Company Do You Work For?	Your Work Address:		Marital Status (Please check one) ☐ Single ☐ Married ☐ Legally Separated ☐ Divorced ☐ Common Law
Job Title:			
Date Employed Full-Time / /	I acknowledge that I am hereby declining all coverage for all my dependents and myself under my employer's plan. [ ] Yes [ ] No		

STEP 2: PLEASE TELL US WHY YOU ARE DECLINING COVERAGE

Employee	☐ Medicare*	☐ Medicaid	☐ Other Health Coverage – Please tell us the plan name	☐ Other Reason – Please explain
Spouse	☐ Medicare*	☐ Medicaid	☐ Other Health Coverage – Please tell us the plan name	☐ Other Reason – Please explain
Children	☐ Medicare*	☐ Medicaid	☐ Other Health Coverage – Please tell us the plan name	☐ Other Reason – Please explain

*** Loss of coverage under Medicare cannot be used as the basis to waive the 6-month waiting period for late enrollees.**

STEP 3: NOTICES, REPRESENTATION & AUTHORIZATION – Please read this section carefully then sign & date the form below

SPECIAL ENROLLMENT NOTICE

If you decline medical and/or dental coverage for yourself, your spouse, or your dependents at this time for any reason, you may later be eligible to enroll yourself, your spouse and/or your newly acquired dependent(s) in medical and/or dental coverage within 30 days of acquiring the dependent(s) through marriage, birth, adoption, or placement for adoption.

If you decline medical and/or dental coverage for yourself or your dependents at this time because of coverage under other health insurance or group health plan coverage, you or your dependents may later be eligible to apply for medical and/or dental coverage without penalty within 30 days after you or your dependents' other health coverage ends (or after the employer stops contributing toward the other coverage), **but only if you state in STEP 2 that other health coverage is the reason for declining coverage.** The penalty for failure to state that other health coverage was the reason for declining this coverage may be a 6-month waiting period under this plan after you apply for coverage hereunder or until the next open enrollment period if any your plan may have.

ADDITIONAL INFORMATION

To request special enrollment or to obtain more information about it, contact the Customer Service Supervisor at American Trust Administrators, Inc. at 800-843-4121.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information may be guilty of a crime.

Employee Signature X_____ **Date Signed** ____/____/____

(PLEASE DO NOT PRINT)