HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself or your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must enroll within 30 days after the marriage, birth, adoption, or placement for adoption.

A special enrollment opportunity may be available in the future if you or your dependents lose other coverage. This special enrollment opportunity will not be available when other coverage ends, however, unless you provide a written statement now explaining the reason that you are declining coverage for yourself or your dependent(s). Failing to accurately complete and return this form for each person for whom you are declining coverage will eliminate this special enrollment opportunity for the person(s) for whom a statement is not completed, even if other coverage is currently in effect and is later lost. In addition, unless you indicate in the statement that you are declining coverage because other coverage is in effect, you will not have this special enrollment opportunity for the person(s) covered by the statement. (See the paragraph above, however, regarding enrollment in the event of marriage, birth, adoption or placement for adoption.)

Effective April 1, 2009 special enrollment rights also exist in the following circumstances: ***In the two below listed circumstances only, you or your dependents will have sixty (60) days to request special enrollment or disenrollment in the group health plan coverage.***

- If you or your dependents experience a loss of eligibility for Medicaid or your State Children's Health Insurance Program (SCHIP) coverage; or

- If you or your dependents become eligible for premium assistance under an optional state Medicaid or SCHIP program that would pay the employee's portion of the health insurance premium.

To request special enrollment or obtain more information, contact your HR Department to add or delete an eligible dependent.

FORM FOR EMPLOYEE TO DECLINE COVERAGE

I received and read a copy of the "Initial Notice of HIPAA Special Enrollment Rights" (the "Notice") at or before the time I was initially offered enrollment in the VBA Group Medical Plan (the "Plan"). I am aware of the warning in the Notice that I will lose some special enrollment rights for myself and my dependents if I decline coverage because I or my dependents have other coverage, **unless** I give the Plan this written statement that the reason I am declining coverage is because I or my dependents have other coverage.

By signing this form, I decline coverage under the Plan for the people listed below. My reason for declining coverage for these people is that they have other coverage under another group health plan or health insurance. I have named the other coverage that is in effect for each person listed, along with the member number or subscriber number for each person.

List all the people whom you could cover under the Plan but are not covering because they have other coverage, including you and your spouse. Use additional paper, if necessary.

Name: _____ Other Coverage and Member/Subscriber No.: _____

Name: _____ Other Coverage and Member/Subscriber No.: _____

Name: _____ Other Coverage and Member/Subscriber No.: _____

Name: _____ Other Coverage and Member/Subscriber No.: _____

Name: _____ Other Coverage and Member/Subscriber No.: _____

Name: _____ Other Coverage and Member/Subscriber No.: _____

Name: _____ Other Coverage and Member/Subscriber No.: _____

Name: _____ Other Coverage and Member/Subscriber No.: _____

Signature: _____

Print Your Name: _____

Date Signed: _____