**ELECTION TO DECLINE BENEFITS**

I understand that as an employee of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ in the Episcopal Diocese of Montana, working 20 or more hours a week, I am eligible for medical and dental insurance. An adequate medical and dental plan, as determined by the Diocese annually, is available to me at no cost. For the reasons cited below, I am electing not to take the options noted below and this is noted in my current letter of agreement

 Medical

My reason for declining coverage is listed below:

I have health insurance coverage through my spouse\_\_\_\_\_\_.

I have TriCare\_\_\_\_\_.

I have Medicare and a Supplement and my church is not reimbursing me for Medicare or the supplement.\_\_\_\_\_\*(note – reimbursement is not allowed).

I understand that my employer may not reimburse me for medical premiums from another insurance provider.

 Dental I am declining dental coverage

Signed:

Date:

Acknowledged:

 Name/Title

Date