Form H12: Voluntary Benefit Declination

This form should be used by employees to confirm their understanding of declining healthcare coverage through the agency. Completed forms should be faxed or mailed to the Human Resources Department.

In accordance with, and compliance of, The Patient Protection and Affordable Care Act of the United States of America, I decline the LIFE Inc. plan coverage, including medical, prescription drug, and vision benefits combined, for myself and any eligible dependents. I certify that I will notify the Benefit Coordinator of LIFE Inc. within thirty-one (31) days if any of the following information changes.

As an eligible employee of LIFE Inc., I understand that I have the option of accepting employee health benefits for myself and my eligible dependents. My option covers the medical, prescription drug, and vision benefits combined. I also understand that I am not entitled to accept certain health benefits and decline others.

I understand that to decline coverage, the only circumstances under which I or my dependents, up to 26 years old, can apply for LIFE, Inc. coverage in the future are:

- Being scheduled for thirty-five (35) hours per week
- During agency-wide open enrollment in March
- After a legally-mandated qualifying event for coverage dependents
- Within thirty (30) days of loss of coverage under another plan as a result of:
    - Loss of qualifying employment
    - Loss of eligibility for another employer's plan
    - Involuntary termination of the other employer's plan
    - Death of a spouse or domestic partner who provided coverage through their employer's plan
    - Divorce from a spouse or domestic partner who provided coverage through their employer's plan

NAME:	SIGNATURE:	DATE:

LIFE Inc.
Living to Fulfilling Environments (LIFE) Inc.