Form H12: Voluntary Benefit Declination

This form is used to decline enrollment in the benefit package offered to eligible employees of Living In Fulfilling Environments (L.I.F.E.), Inc. in accordance to the requirements of The Patient Protection and Affordable Care Act.

NAME:	PROGRAM:	DATE:

In accordance with, and compliance of, The Patient Protection and Affordable Care Act of the United States of America, I decline the Living In Fulfilling Environments (L.I.F.E.), 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 Living In Fulfilling Environments (L.I.F.E.), Inc. within thirty-one (31) days if any of the following information changes.

As an eligible employee of Living In Fulfilling Environments (L.I.F.E.), 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 Living In Fulfilling Environments (L.I.F.E.), Inc. coverage in the future are:

- *Being scheduled for thirty-five (35) hours per week*
- *During agency-wide open enrollment*
- *After a legally-mandated permitting event for coverage of dependents*
- *Within thirty (30) days of loss of coverage under another plan as the result of:*
  - » *Loss of qualifying employment*
  - » *Loss of eligibility for other 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*

EMPLOYEE PRINTED NAME:	EMPLOYEE SIGNATURE:	DATE:

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