



Declination of LACCD Health & Life Benefits

LACCD offers dental, medical, vision, and basic life benefits plans to all of its employees and their dependents.

Each employee has the right to decline any of these benefits. **If you decline health and/or life benefits, you will only be able to elect benefits in the future either during annual Open Enrollment or in the event that you experience a qualifying life changing event.**

By completing this Declination of Benefits form, I hereby acknowledge that I have been offered dental, medical, vision, and basic life insurance benefits by LACCD.

I **decline dental** benefits through LACCD for:

Myself Spouse Dependent Child(ren)

I **decline medical** benefits through LACCD for:

Myself Spouse Dependent Child(ren)

I **decline vision** benefits through LACCD for:

Myself Spouse Dependent Child(ren)

I decline basic life and AD&D benefits.

I understand that by declining health and/or life benefits at this time, that **I will not be covered** by LACCD dental, medical, vision, and/or basic life benefits unless I later complete applications for such either during Annual Open Enrollment or in the event I experience a qualifying life changing event that allows me to enroll outside of the Annual Open Enrollment Period.

Name: _____ Employee # _____

Signature: _____ Date _____