



BENEFITS

YOUR HEALTH YOUR WEALTH YOUR JOB

DECLINE COVERAGE ACKNOWLEDGEMENT FORM

YOUR EE# _____

CHECK THE BOX THAT APPLIES TO YOU

1. **DECLINE HEALTH COVERAGE – COVERED AS THE DEPENDENT OF ANOTHER COSTCO EMPLOYEE**

I am a *benefit eligible* Costco employee who qualifies and is enrolled in health coverage as a dependent of another benefit eligible Costco Employee:

Employee I am covered under _____ Their EE # _____

- I will receive health coverage as elected by the above employee.
- I will receive Basic Life, AD&D, and Long Term Disability Insurance.
- I may elect to participate in the Health Care Reimbursement Account and Dependent Care Assistance Plan, as well as Supplemental Life Insurance, Supplemental AD&D Insurance and Long Term Care Insurance. I must elect these benefits according to the rules and time periods described in the SPD for the Costco Benefits Program.

2. **DECLINE WITH ANCILLARY COVERAGE (COVERED UNDER ANOTHER PLAN)**

I decline coverage under Costco's Health plans and elect to pay for LTD plan coverage. Premiums for LTD coverage will be withheld from my wages on a pre-tax basis.

- I will receive Basic Life and AD&D Insurance coverage.
- I may elect to participate in the Health Care Reimbursement Account and Dependent Care Assistance Plan, as well as Supplemental Life Insurance, Supplemental AD&D Insurance and Long Term Care Insurance. I must elect these benefits according to the rules and time periods described in the SPD for the Costco Benefits Program.

3. **DECLINE ALL COVERAGE**

I decline all Program coverage.

- I will not have any coverage under the Program for health care, Life Insurance, AD&D Insurance, Long Term Disability Insurance, or Long Term Care Insurance.
- I may not elect to contribute to the Health Care Reimbursement Account or Dependent Care Assistance Plan.

I may not change the benefit elections on this form until the next annual Open Enrollment, unless I experience a qualified change in status (as defined by the Program)

I understand that different eligibility and enrollment rules apply to Voluntary Short Term Disability (STD). Once I am eligible for STD, I must complete a different form to opt out of STD coverage.

I have read the Summary Plan Description and Enrollment Materials for the Costco Employee Benefits Program and I understand my rights to benefits under the Program. I hereby knowingly and voluntarily elect to decline coverage under the Program as designated herein. I have had sufficient time to consider this waiver and I agree that I will not hold Costco or the Program responsible if it turns out that declining coverage under the Program was not to my advantage.

_____	_____
Your Name (Printed)	Employee Number
_____	_____
Signature	Date

NOTICE OF SPECIAL ENROLLMENT

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 and 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 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 a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days of marriage and 60 days of birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact the Costco Employee Benefit Department at 1-800-284-4882.