



Benefits Declination Form

Health Care Benefits

As a member of the CESC program, I, \_\_\_\_\_ (member name), am entitled to health care benefits, but I am hereby declining those benefits because I am covered by another plan as a subscriber or as a dependant.

Insurance Company \_\_\_\_\_

Policy # \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Child Care Benefits

\_\_\_\_ I do not have children.

\_\_\_\_ I am not a full-time member or I am not serving in a full-time capacity.

\_\_\_\_ I am a full-time member or serving in a full-time capacity and entitled to child care benefits. I am hereby declining those benefits.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Loan Forbearance

\_\_\_\_ I do not have outstanding student loans or do not request loan forbearance.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_