EMPLOYER HEALTH BENEFITS WAIVER OF COVERAGE FORM

Group Policy No.: ----------

Policyholder Name: ----------

Employee Name: ---------- Social Security #: ----------
Last First MI

Marital Status (circle one): Single Married Widowed Divorced

Date of Employment: ---------- Date of Birth: ----------

I was given the opportunity to enroll in this plan of group health benefits offered by my employer and I *refuse* the following:

- ☐ Employee, Spouse, and Child(ren) coverage
- ☐ Spouse coverage
- ☐ Child(ren) coverage

Reason for Refusal (Please check all appropriate boxes.)

- ☐ other fully-insured Group Health Plan sponsored by this employer
- ☐ other Group Health Plan sponsored by my spouse's employer
- ☐ other group coverage sponsored by another organization
- ☐ covered under Medicare
- ☐ other reasons (please explain) ----------

Please identify Group Health Plan(s) and provide names(s) of Policyholder(s), carrier(s) and policy number(s).

Policyholder/Name: ----------

Carrier: ---------- Policy number: ----------

Policyholder/Name: ----------

Carrier: ---------- Policy number: ----------

Policyholder/Name: ----------

Carrier: ---------- Policy number: ----------

Policyholder/Name: ----------

Carrier: ---------- Policy number: ----------

If you are declining enrollment for yourself or your dependents (including your spouse) because of other Group Health Plan coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. 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 provided, that you request enrollment within 30 days after marriage, birth, adoption or placement for adoption.

If the reason for the refusal of coverage is coverage under another Group Health Plan, it is important to provide information concerning that Group Health Plan on this Waiver of Coverage form.

I understand that if I later wish to enroll for any of the coverage(s) refused, I can only do so during Open Enrollment or if there is an eligible qualifying event.

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Signature of Employee Date

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Signature of Witness Date