



## Health Insurance Waiver Form

A. Please check the box which identifies the coverage you wish to decline: Medical  Dental  Vision

B. I would like to decline coverage for: Employee  Spouse  Dependant children  Spouse and children

C. Reason for declining coverage: (Check one)

- Covered by spouse's group coverage – Carrier name and I.D. number: \_\_\_\_\_
- Enrolled in any other insurance carrier plan – Carrier name: \_\_\_\_\_
- Military
- Medicare
- Other (Explain): \_\_\_\_\_

I acknowledge that the available coverage has been explained to me by my employer and I understand that I have every right to apply for coverage. I have been provided the opportunity to apply for this coverage and I have declined to enroll myself and/or my dependent(s), if any. I have made this decision voluntarily. BY DECLINING THIS GROUP HEALTH COVERAGE (UNLESS EMPLOYEE AND/OR DEPENDENTS HAVE GROUP HEALTH COVERAGE ELSEWHERE), I ACKNOWLEDGE IF WE APPLY FOR COVERAGE AFTER OUR ORIGINAL ELIGIBILITY DATE FOR THIS INSURANCE, MY DEPENDENT(S) AND I MAY BE CONSIDERED LATE ENTRANT(S) AND THEREFORE NOT ELIGIBLE UNTIL THE NEXT OPEN ENROLLMENT.

You will not be considered a late enrollee if:

1. You or your waiving Dependents were covered under another health plan at the time of this waiver; and you execute this form at the time of waiving coverage;
  - a) You have lost coverage under another health plan as a result of: I) termination of employment; II) change in employment status; III) termination of the other plan's coverage; IV) cessation of an employer's premium contribution toward an employee's or dependant's coverage; or death of the individual through which the waiving individual was covered as a Dependant, or divorce, and
  - b) You request enrollment within 30 days after termination of coverage or Employer contribution under another employer health benefit plan; or,
2. A court orders coverage be provided for a spouse or child of an insured Employee and request for enrollment under this plan is made within 30 days of the issuance of the court order; or,
3. He or she is employed by an Employer that offers multiple health plans and the Employee elects a different plan during an open enrollment period.

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

Print Employee Name: \_\_\_\_\_

Social Security #: \_\_\_\_\_

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