Logo

WAIVER OF MEDICAL COVERAGE

Employer Company Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On behalf of myself and my eligible dependents (if any), I waive the option to enroll in [COMPANY NAME] health insurance offered at this time by or through my employer for the following reason:

☐ I am covered under another group plan as a spouse or dependent
☐ I am covered by Medicare or Veterans Program
☐ I have purchased subsidized coverage through state or federal Exchange

☐ I am covered under another group plan sponsored by a second employer

*For each person declining to enroll in [COMPANY NAME] medical coverage at this time because of other health care coverage listed above, please provide the following information:*

Subscriber Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Carrier Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group/Policy Number: \_\_\_\_\_\_\_\_\_\_\_

☐ I am covered under another carrier’s plan sponsored by this employer
☐ I am covered through an Individual plan, or purchased coverage through state or federal Exchange with no subsidy
☐ I do not wish to participate in health care benefits at this time (I am declining health insurance entirely)

**Notice of Enrollment Rights**

*If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this health 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 the marriage, birth, adoption, or placement for adoption.*

I understand that any person choosing to enroll later must meet [COMPANY NAME] requirements for eligibility and for late enrollees.

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

**I affirm that the assertions in this form are true and complete to the best of my knowledge, and I understand that [COMPANY NAME] has the right to terminate coverage, retroactive to the effective date of coverage, for any material misinformation (including omissions) contained in this form.**

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