WAIVER FORM – MEDICAL COVERAGE ONLY

EMPLOYEE NAME:_____

COMPLETE & SIGN BELOW ONLY IF YOU HAVE CHOSEN TO WAIVE MEDICAL COVERAGE:

I acknowledge that I have been offered the opportunity to be enrolled in health coverage for myself and my dependents through my employer's plan.

☐ **I have elected to waive coverage at this time because I have other medical coverage provided by:**

Insurance company name:_____

Policy Number:_____

Through (Employer Name):_____

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health care coverage, you may only enroll yourself or your dependents in this plan prior to the next open enrollment period (under limited certain circumstances). To do this, you must have involuntarily lost your other coverage and we must receive your enrollment application within 30 days after your other coverage ended.

Additionally, if you have new dependents as a result of marriage, birth, adoption or placement for adoption, or because you or your child(ren) are eligible for Medicaid or State Children's Health Insurance Program, you may be able to enroll yourself and dependents, provided we receive your completed enrollment application within 60 days of these events.

☐ **I do not wish to enroll myself and/or my dependent spouse and/or children in any type of medical coverage and waive my right to enroll.**

EMPLOYEE SIGNATURE:_____ DATE_____