Waiver of Group Coverage

Company Name: ____

Employee Name: ______________________________ Date of Birth: ______________

Please Check One:

☐ I waive my employer's group health insurance coverage for myself, and my dependents (if any).

☐ I am enrolling in my employer's group health insurance coverage but I am waiving coverage for my dependents.

Reason for Waiving Coverage - Please Check One:

☐ Covered through spouse's employer, or; ☐ Covered through a parent's employer

Employer Name: ____

Insurance Company: ____

☐ Other reason (explain): ____
____

Employee Signature: ______________________________ Date: ______________

IMPORTANT: If you checked that you are declining coverage due to other coverage, you will be eligible to enroll in this Plan within 30 days of the date that you are no longer eligible for the other coverage. If you did not state that the reason for waiving coverage is due to other coverage, then you cannot enroll in this Plan until your employer's open enrollment period (absent acquiring a new dependent through birth, marriage or adoption.).