Waiver of Coverage Confirmation Form

I am electing to waive the medical coverage offered by my employer. I am waiving this coverage because:

☐ **1) I have medical insurance coverage through**

- ☐ spouse/domestic partner
- ☐ parent or guardian.
- ☐ Medicare.
- ☐ Medicaid or other state or federally funded programs.
- ☐ Cobra from previous employer. End date:_____
- ☐ Other (list) _____

Carrier:_____

Effective Date:_____

☐ **2) I am electing to waive coverage but do not have alternate medical insurance coverage.**

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3) Employer:_____

Employee Name (print): _____

Signature: _____

Date: _____