Waiver of Group Health Benefits

Employee Name

Job Title

Employee Number (ID, Social Security, etc.)

For the plan year effective I am waiving coverage for:

☐ Myself

☐ Spouse/Domestic Partner

☐ Dependents(s):

If selecting Dependent(s), please list their name(s):

I am waiving coverage due to:

☐ My preference is not to have coverage

☐ Coverage under my spouse's/domestic partner's plan

☐ Other coverage

This other coverage is:

☐ Employer-sponsored Group Plan ☐ Individual policy ☐Medicare ☐ COBRA ☐TRICARE ☐ Medicaid

Special Enrollment Notice and Certification – *Please review and sign below if you wish to waive coverage*

By signing below, I certify that I have been given an opportunity to apply for coverage for myself and my eligible dependents, if any. I am declining enrollment as indicated above. I understand that, if I am declining enrollment for myself or my eligible dependents (including my spouse) because of other health insurance or group health plan coverage, I may be able to enroll myself and my eligible dependents in this plan if I lose, or my eligible dependents lose, eligibility for that other coverage (or if the employer stops contributing towards my or my eligible dependents' other coverage).

I understand that I must request enrollment no more than 30 days after the date the other health plan coverage ends (or after the employer stops contributing toward the other coverage). If I do not do so, I will not be able to enroll until my employer's next annual open enrollment period.

In addition, I understand that if I have a newly eligible dependent because of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my eligible dependent(s). However, I must request enrollment within 30 days after marriage, birth, adoption, or placement for adoption.

I understand that to request special enrollment or obtain more information, I should contact my group administrator.

Employee Signature Date