

## Waiver of Group Coverage

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

Employee Name: \_\_\_\_\_\_ Date of Birth: \_\_\_\_\_

Health Plan (Product) Effective Date: \_\_\_\_\_ Average number of hours working weekly \_\_\_\_\_

I understand that I am eligible to participate in my employer's group health insurance coverage and that my employer is contributing the following amount to the health plan(s) premium:

Product Name: \_\_\_\_\_

Monthly Contribution Dollar Amount:

Single \$\_\_\_\_\_ Family \$\_\_\_\_\_ Other (amount & tier) \$\_\_\_\_\_ \$\_\_\_\_\_

Product Name: \_\_\_\_\_

Monthly Contribution Dollar Amount:

Single \$\_\_\_\_\_ Family \$\_\_\_\_\_ Other (amount & tier) \$\_\_\_\_\_ \$\_\_\_\_\_

## **Please Check All That Apply:**

[] I waive my employer's group **health** insurance coverage for myself and my dependents (if any).

[] I waive my employer's group **dental** insurance coverage for myself and my dependents (if any).

## **Reason for Waiving Coverage - Please Check One:**

[] Covered through spouse's employer [] Covered through a parent's employer

[] Under 65 Retiree covered by previous employer's insurance program

[] Other Please specify: \_\_\_\_\_

## Please Read and Sign Below:

In waiving coverage, I understand that I and/or my dependents may enroll under this plan in the future only as the result of certain qualifying conditions. For example,

- Within 30 days of involuntarily loss of other group coverage

- At the time of my employer's open enrollment.

Signature: The undersigned certifies that, to the best of my knowledge and belief and under penalty of perjury, the information listed above is true and complete.

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

Date:

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