## Waiver of Group Coverage

Company Name: $\qquad$
Employee Name: $\qquad$ Date of Birth: $\qquad$
Health Plan (Product) Effective Date: $\qquad$ Average number of hours working weekly $\qquad$

## 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:

$\qquad$
Monthly Contribution Dollar Amount:
Single \$ $\qquad$ Family \$ $\qquad$ Other (amount \& tier) \$ $\qquad$ \$ $\qquad$

## Product Name:

$\qquad$
Monthly Contribution Dollar Amount:
Single \$ $\qquad$ Family \$ $\qquad$ Other (amount \& tier) \$ $\qquad$ \$ $\qquad$

## 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: $\qquad$

## 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: $\qquad$ Date: $\qquad$

