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Group Health Plans Waiver of Coverage

Employee Name: _____

Social Security Number: _____

Group Case #: _____

Employer Name: _____

Life Coverage? Keep/Accept or Waive/Decline

Request to Waive Coverage

I, and/or my dependents, request to decline coverage because of:

	Other Group Coverage	Covered under Individual Medical	Covered under Government Sponsored Plan	COBRA Coverage	Other	No Coverage
Employee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spouse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child(ren)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If declining coverage due to other coverage, please list the name and phone number of the insurance company (or employer if covered through a self-funded plan) and policy number :

Name(s) of covered family members	Insurance company name, if known, or employer if self-funded	Primary Insured & SSN	Policy Number, if known

This is to acknowledge I have been given the opportunity to apply for the available coverages and have elected not to enroll myself or my dependents, if any. I understand that by applying for coverage at a later date I may be considered a Late Applicant. If I am a Late Applicant, I will be subject to an 18-month pre-existing exclusion limitation period. I represent I have not been persuaded to waive coverage by my employer or the producing agent.

I understand that if I waive coverage for myself or my dependents because of being covered under other health insurance coverage, I may, in the future, be able to enroll myself or my dependents in this plan if the other health insurance coverage terminates. The other health coverages must have terminated because of either: 1) the "loss of eligibility" for coverage, or 2) the termination of the employer plan by the employer. I understand that I must apply for coverage within 30 days of a qualifying life event or termination of other coverage to be eligible for a special enrollment period. "Loss of eligibility" includes a loss of coverage due to legal separation, divorce, death, termination of employment, or a reduction in the number of hours of employment. Loss of eligibility does not include an individual's failure to pay premiums on a timely basis or in the event of termination of coverage for cause. Examples of a loss of coverage for cause include the making of a fraudulent claim or an intentional misrepresentation of fact in connection with a group health plan.

In addition, if I have a new dependent as a result of marriage, birth, adoption or placement for adoption, I understand I may be able to enroll myself and certain dependents, provided that I apply within 30 days after the marriage, birth adoption, or placement for adoption.

X _____
Signature of Employee _____ Date _____