



WAIVER OF COVERAGE



Employee's Information

Last Name	First Name	Middle Initial
Mailing Address		
City	State	ZIP
Social Security Number		
Employer's Name		Date of Hire

Persons Declining Coverage & Reason

Last Name	First Name	MI	Date of Birth	Relationship to Employee (self, spouse, son, daughter)	Reason for Declining Coverage (Use codes below)
<i>Example: Doe</i>	<i>John</i>	<i>A.</i>	<i>03/25/2005</i>	<i>son</i>	<i>CP</i>

Reasons for Declining Coverage

- | | |
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| <ul style="list-style-type: none"> CS – Covered under Spouses employer's insurance policy CE – Covered under my other employer's policy CR – Covered under retirement benefits CP – Covered under my parent's insurance policy CAP – Covered under another parent's insurance policy | <ul style="list-style-type: none"> CI – Covered under self-purchased individual policy CM – Covered under Medicare or Medicare Advantage CMD – Covered under Medicaid NO – I do not want health insurance and I have no other coverage. |
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Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Employees Acknowledgement and Signature

I, on behalf of any and all persons listed above as waiving coverage (hereafter, "Person Waiving Coverage"), acknowledge that any Person Waiving Coverage is declining coverage without inducement or pressure by my employer or the insurer. I understand that any Person Waiving Coverage who later wants to participate in the plan will not be able to enroll until the next open enrollment period, unless the plan is a small employer's plan (in which case, a Person Waiving Coverage may apply any time, but he/she will be subject to an 18-month pre-existing condition exclusion period). I also understand that if a Person Waiving Coverage loses his/her other coverage, if any, as a result of termination of employment, cessation of employer contributions, exhaustion of COBRA continuation coverage or other involuntary loss of eligibility, the Person Waiving Coverage will have a special enrollment right. The Person Waiving Coverage also has a special enrollment right in the event of marriage or a child's birth, adoption or placement for adoption. I understand that, to use a special enrollment right, a Person Waiving Coverage must submit an enrollment form within 31 days from the occurrence of the special enrollment event.

Employee Signature

Date Signed