



WAIVER OF HEALTH CARE COVERAGE FORM

Important Notice About Special Enrollment Periods: If you are declining enrollment for yourself or your dependents (including your spouse[or domestic partner]) because of other health care coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within thirty-one (31) days after your other coverage ends. 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, provided that you request enrollment within thirty-one (31) days after the marriage, birth, adoption, or placement for adoption.

Identity of Plan:

Name of Employer Policy or Plan Number

Identity of Employee:

Name Social Security Number

Home Address

Complete 1 or 2 below if you are electing not to enroll yourself or one or more family members for health care coverage available under this group policy or plan:

I elect not to enroll myself or my eligible dependents for health care coverage at this time because of:
other health care coverage (identify)
other reasons (please explain)

I elect to enroll myself for health care coverage, but not to enroll the following eligible dependents at this time
Spouse[/Domestic Partner] (name)
Children (names)
because of:
other health coverage (identify)
other reasons (please explain)

I understand that failure to elect health care coverage under the plan when initially eligible may result in total exclusion from health care coverage under the plan.

If your plan provides for future open enrollment periods, you may be allowed to enroll yourself or your family members at that time. Ask your employer. Otherwise, any person not enrolled when first eligible may be excluded from health care coverage unless a Special Enrollment Period occurs, as described in the Important Notice above.

Employee Signature Date Signed