

**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: \_\_\_\_\_