univera HEALTHCARE

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:_____