

## Employee's Waiver of Health Care Coverage

If you decline to enroll either yourself or your eligible family members in the health care coverage offered by your employer, we ask that you complete this form. **Qualified late enrollees who decline coverage may not reapply for coverage until their employer's policy renewal date or experience a qualifying event.**

I certify that I have been informed of the availability of coverage under my employer's health benefit plan, but I choose not to enroll (please check all that apply and list each eligible family member's name):

☐ myself \_\_\_\_\_ ☐ my eligible child(ren): \_\_\_\_\_

☐ my spouse \_\_\_\_\_

I have chosen to decline health care coverage at this time because:

☐ I and/or my dependents have other group or individual coverage with (name of insurance company) \_\_\_\_\_

through (insured's name and relationship) \_\_\_\_\_

☐ Other reason(s) to waive coverage (please specify): \_\_\_\_\_

I understand that if, at this time, I decline coverage offered by my employer for myself or my eligible family members, and then choose to apply for coverage later, the plan may exclude coverage, except in the following instances:

1. The individual meets each of the following:

- a. The individual(s) lost coverage as a result of termination of employment or eligibility, the involuntary termination as a result of a qualifying event.
- b. The employer stops contributing towards your or your dependents' other coverage; and
- c. The individual request submits a enrollment application within 30 days after termination or qualifying event.

2. A court has ordered that coverage be provided for a spouse or minor or dependent child under a covered employee's health benefit plan and request for enrollment is made within 30 days after issuance of the court order; or

3. If an individual seeks to enroll a dependent(s) during the first sixty (60) days of eligibility, the coverage of the dependent(s) shall become effective:

- a. in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received after the application is received;
- b. in the case of a dependent's birth, as of the date of such birth; or
- c. in the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

\_\_\_\_\_  
Please print name

\_\_\_\_\_  
Name of group

\_\_\_\_\_  
Social Security number

\_\_\_\_\_  
Group number

\_\_\_\_\_  
Employee's signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Group administrator's signature

\_\_\_\_\_  
Date