



WAIVER OF COVERAGE

Employee Name _____
(Please print)

Social Security Number _____

Company Name _____

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 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 31 days after the marriage, birth, adoption, or placement for adoption.

This is to acknowledge that my employer explained the benefit plans available to me. I was given the opportunity to apply for the available benefit plans and have elected not to enroll.

Reason for declining coverage:

_____ I am covered through my spouse's employer*

Name of spouse's employer _____

Name of Insurance Company _____

Type of Insurance: Single ___ Family ___ Group # _____

_____ I am covered through the Federal Government*

_____ CHAMPUS or CHAMPVA _____ Medicare _____ Medicaid

Does the above cover all family members? ___ Yes ___ No

_____ I am covered through an individual policy*

Name of Insurance Company _____

Type of Insurance: Single ___ Family ___ Effective Date ___ Policy # _____

_____ I have no insurance

Employee Signature _____ Date _____

*Please include a copy of your insurance card.