



## WAIVER OF HEALTH COVERAGE

\_\_\_\_\_  
Full Name of Employee (Please print.)

\_\_\_\_\_  
Name of Employer

My employer has given me an opportunity to apply for group health coverage with the plan for myself and my dependents (if applicable). I have declined to apply for coverage for the reason indicated below.

### REASON FOR DECLINING COVERAGE (Must check one.)

- Covered under spouse's group health insurance policy.**  
(If this box is checked, information below is required.)

\_\_\_\_\_  
Insurance Company Name

\_\_\_\_\_  
Subscriber/Policyholder's Name

\_\_\_\_\_  
Subscriber/Policyholder's Social Security Number and Date of Birth

- Medicare**
- Medicaid**
- Other**

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

I understand that if I decide to apply for health coverage for myself and my dependents (if applicable) at a later date, neither I nor my dependents will be eligible for coverage until (i) my employer's next annual enrollment or (ii) there is a significant change in family status or employment status as determined by my employer's health plan.

\_\_\_\_\_  
Employee Signature in Ink

\_\_\_\_\_  
Date