# WAIVER OF COVERAGE

| Employee Name (Please print clearly): | Date of Birth: |
|---|---|
| Social Security Number: | Employer's Name: |

This is to acknowledge that the available coverage has been explained to me by my employer. I have been given the opportunity to apply for the available coverage and have elected not to enroll myself or my dependents for the following reason(s):

☐ I am covered under another group health plan as a spouse or dependent.

☐ I am covered by ☐ Medicare ☐ Medicaid ☐ CHAMPUS ☐ CHAMPVA

☐ I am covered through an individual policy.

If you checked one of the above, please attach a copy of your insurance card or complete the following:

| Subscriber Name: | | Carrier: |
|---|---|---|
| Member/Policy Number: | Group Number: | Member Services Telephone Number: |

(If subscriber has more than one coverage plan, please indicate below.)

| Subscriber Name: | | Carrier: |
|---|---|---|
| Member/Policy Number: | Group Number: | Member Services Telephone Number: |

☐ I do not wish to participate in health care benefits at this time and I have no other health care coverage.

If you are currently declining enrollment for yourself or your dependent (including your spouse) because of other health coverage, you may be able to enroll yourself or your dependents in this plan at a later time, 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, adoption, or placement for adoption or within 60 days as permitted for newborns.

Special enrollment rights may also apply if you lose coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for state premium assistance under Medicaid or CHIP. An employee or dependent who loses coverage under Medicaid or CHIP as a result of the loss of Medicaid or CHIP eligibility may be able to enroll in this plan, if enrollment is requested within 60 days after Medicaid or CHIP coverage ends. An employee or dependent who becomes eligible for group health plan premium assistance under Medicaid or CHIP may be able to enroll in this plan if enrollment is requested within 60 days after the employee or dependent is determined to be eligible for such premium assistance.

| Signature: | Date: |
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