Waiver of Group Health Benefits & Notice of Special Enrollment Rights

Employer Name: _____

Employee Name: _____ _____ _____
(Last) (First) (MI)

For the plan year effective ___/___/___ I am waiving coverage for:
(MM/DD/YY)

☐ Myself

☐ Spouse/Domestic Partner

☐ Dependent (s) – Please list names: _____

I am waiving coverage due to:

☐ My preference not to have coverage

☐ Other coverage

Special Enrollment Notice and Certification – *Please review and sign below if you wish to waive coverage*

By signing below, I certify that I have been given an opportunity to apply for coverage for myself and my eligible dependents, if any. I am declining enrollment as indicated above. I understand that if I am declining enrollment for myself or my eligible dependents (including my spouse) because of other health insurance or group health plan coverage, I may be able to enroll myself and my eligible dependents in this plan if I lose, or my eligible dependents lose, eligibility for that other coverage (or if the employer stops contributing towards my or my eligible dependents' other coverage).

I understand that I must request enrollment no more than 30 days after the date the other health plan coverage ends (or after the employer stops contributing toward the other coverage). If I do not do so, I will not be able to enroll until my employer's next annual open enrollment period.

In addition, I understand that if I have a newly eligible dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my eligible dependent(s). However, I must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

I understand that to request special enrollment or obtain more information, I should contact my group administrator.

_____

Signature of Employee Date of Signature

Please Return to your Executive Director