



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

- 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