

J. WAIVER OF COVERAGE

COMPLETE WHEN WAIVING COVERAGE FOR SELF AND/OR DEPENDENTS

Employer: _____

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

INDIVIDUALS WAIVING COVERAGE

Name of Individual waiving coverage	Insurer and phone number	Date of Coverage MM/YYYY		Will coverage continue?	Type of Coverage (Check all that apply)		
		Start Date	End Date		<input type="checkbox"/> Group <input type="checkbox"/> Medical	<input type="checkbox"/> Individual <input type="checkbox"/> Dental	<input type="checkbox"/> Governmental <input type="checkbox"/> Other
Employee:				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Medical	<input type="checkbox"/> Individual <input type="checkbox"/> Dental	<input type="checkbox"/> Governmental <input type="checkbox"/> Other
Spouse / Domestic Partner:				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Medical	<input type="checkbox"/> Individual <input type="checkbox"/> Dental	<input type="checkbox"/> Governmental <input type="checkbox"/> Other
Dependent:				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Medical	<input type="checkbox"/> Individual <input type="checkbox"/> Dental	<input type="checkbox"/> Governmental <input type="checkbox"/> Other
Dependent:				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Medical	<input type="checkbox"/> Individual <input type="checkbox"/> Dental	<input type="checkbox"/> Governmental <input type="checkbox"/> Other
Dependent:				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Medical	<input type="checkbox"/> Individual <input type="checkbox"/> Dental	<input type="checkbox"/> Governmental <input type="checkbox"/> Other

HEALTH STATEMENT

Pregnancy / Adoption: Is any individual waiving coverage pregnant or financially responsible for an unborn child? If currently pregnant, provide expected due date: _____ ▶ Do you anticipate complications or multiple births? ▶ Have you had prior complications or multiple births?	YES	NO

IF "YES", PROVIDE DETAILS IN THIS SECTION Attach a separate sheet if necessary.

Name of Individual	Explain diagnosis, illness, treatment received, testing, consultations, future treatments, and remaining symptoms or problems	Diagnosis/Treatment date(s)		Physician, clinic, or hospital name. If known, provide phone number or address.
		Start Date MM /YYYY	Start Date MM /YYYY	

ACKNOWLEDGEMENT AND SIGNATURE

I acknowledge that I have had the opportunity to enroll, but do not wish to make application for those individual(s) listed above. In waiving coverage, I am aware that waiving individuals (including myself, if I am waiving) may not enroll until my group's anniversary, unless the waiving individual qualifies for a Special Enrollment Period (SEP). If I have waived enrollment for myself or any of my dependents (including my spouse) because of other health care coverage or group health plan coverage, I may in the future be qualified for a SEP and be able to enroll the waived individuals in this plan, provided I request enrollment within 30 days after the other coverage of the individual(s) ends due to loss of eligibility or an employer's ceasing to contribute toward that other coverage (within 60 days if the other coverage was Medicaid or CHIP). In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents, provided that I request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

I further certify that all information completed on this form is true, correct and complete, and acknowledge my coverage is subject to cancellation or other action permissible by law, if any completed information is found to be false or incorrect.

Employee Signature _____ Date _____