Waiver of Group Health Insurance Benefits

Employer's Name (Please Print)

Employee's Name (Please Print)

PLEASE CHOOSE THE APPLICABLE OPTION BELOW.

I choose to decline enrolling myself and/or my eligible dependent(s) in the group insurance plan(s) indicated below. *

**Please indicate your waiver of coverage by checking all applicable categories and selected family members.*

- ☐ *Group Medical Plan*
- ☐ *Exclude Myself*
- ☐ *Exclude My Spouse*
- ☐ *Exclude My Child(ren)*

Reasons for declining coverage:

- ☐ *Covered by Spouse's plan*
- ☐ *Covered by other insurance*
- ☐ *Covered by HMO*
- ☐ *Other (Explain)*

I acknowledge that my employer has explained the coverage(s) available.

I have been given the opportunity to enroll in my employer's group medical plan for the coverage(s) and have elected not to enroll myself and/or my dependents, if any.

I understand that I will not be able to enroll in the plan until the next open enrollment period.

Electronic Employee Signature_____ Date_____

ONLY COMPLETE AND SIGN THIS FORM IF COVERAGE IS BEING WAIVED