2023

Waiver of Coverage Form

Employee Name (Please Print): _____

Waiver Of Group Medical Coverage (Please Check One):

- ☐ I waive my employer's group health coverage for myself and dependents (if any).
- ☐ I am enrolling in my employer's group health insurance coverage but I am waiving coverage for my dependents (if any).

Waiver Of Group Dental Coverage (Please Check One):

- ☐ I waive my employer's group health coverage for myself and dependents (if any).
- ☐ I am enrolling in my employer's group health insurance coverage but I am waiving coverage for my dependents (if any).

Reason For Waiver Of Group Coverage (Please Check One):

- ☐ Coverage through spouse's employer:

  Employer Name: _____

  Insurance Company: _____

- ☐ Other reason (please explain)

_____

_____

_____

Employee Statement:

As a result, I waive my, and/or my dependents' (if any) eligibility to enroll in my employer's group health plan(s) currently. I understand that I and/or my dependents may enroll under these plans in the future only within 30 days from loss of other group coverage or at the time of my employer's annual open enrollment.

Employee Signature _____ **Date** / /