2027

Waiver of Coverage Form

Employee Name (Please Print): _____

Waiver Of Group Medical Coverage (Please Check One):

☐ I waive my employer's group medical coverage for myself and 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)

_____

_____

Dental and Vision Group Coverage:

If you want to enroll in Dental and Vision coverage, please use the enrollment link sent to your personal email address. The link shows what the plan covers and how much it costs. If you prefer to use a paper form to enroll in Dental and Vision coverage, please check this box. ☐ We will email you the form for you to fill out, along with information about the plans.

Employee Statement: By signing below, I acknowledge that I have been given the opportunity to enroll in my employer's group medical, dental, and vision coverage.If I waive coverage, I understand that I am declining coverage for myself and/or my eligible dependents, if applicable. I understand that I may enroll in the applicable plan in the future only if I experience a qualifying event, such as the loss of other group coverage, and make the election within the applicable enrollment period, or during my employer's annual open enrollment period.I certify that the information provided on this form is accurate and complete.

Employee Signature _____ **Date** _____