WAIVER OF COVERAGE

PRIOR TO DECLINING COVERAGE, PLEASE READ THE FOLLOWING STATEMENT

An eligible employee or dependent shall not be considered a late enrollee if any of the following is applicable:

1) The individual meets all of the following requirements:
   A) The individual was covered under another employer health benefit plan at the time the individual was eligible to enroll.
   B) The individual certified, at the time of the initial enrollment, that coverage under another employer health benefit plan was the reason for declining enrollment provided that, if the individual was covered under another employer health plan, the individual was given the opportunity to make the certification required by this term #1 and was notified that failure to do so could result in later treatment as a late enrollee.
   C) The individual has lost or will lose coverage under another employer health benefit plan as result of termination of the individual or of person through whom the individual was covered as a dependent, change in employment status of the individual or of a person through whom the individual was covered as a dependent, termination of the other plan's coverage, cessation of an employer's contribution toward an employee or dependent's coverage, death of a person through whom the individual was covered as a dependent, or divorce.
   D) The individual must request enrollment within 30 days after termination of coverage, or cessation of employer contribution toward coverage provided under another employer health benefit plan.

2) The individual is employed by an employer that offers multiple health benefits and the individual elects a different plan during an open enrollment period.

3) A court has ordered that coverage be provided for spouse or minor child under a covered employee's health benefit plan and request for enrollment is made within 30 days after issuance of the court order.

CHECK ANY AND ALL BOXES THAT APPLY. ELIGIBLE DEPENDENTS AGE 19 OR OVER MUST ALSO SIGN BELOW.

☐ I elect to decline coverage through my employer's health benefit plan because:
   ☐ I am covered under another employer's health benefit plan.
   ☐ I am covered as a dependent through another employer's health benefit plan.
   ☐ I have other coverage. Please give details: _____

☐ I elect to decline coverage for my dependents through my employer's health benefit plan because:
   ☐ Each individual is covered, as an employee or dependent, under another employer's health benefit plan.
   ☐ Each individual has other coverage. Please give details: _____

I UNDERSTAND THAT FAILURE TO ELECT COVERAGE DURING THE INITIAL ENROLLMENT PERIOD PERMITS THE CARRIER TO IMPOSE, AT THE TIME OF MY LATER DECISION TO ELECT COVERAGE, AN EXCLUSION FROM COVERAGE FOR A PERIOD OF TWELVE MONTHS AS WELL AS A SIX-MONTH PRE-EXSITING CONDITION EXCLUSION, UNLESS I MEET THE CRITERIA SPECIFIED ABOVE.

GROUP NAME: _____

Signature of Employee	Print Name	Date
Signature of Spouse	Print Name	Date
Signature of Dependent age 19 or over	Print Name	Date
Signature of Dependent age 19 or over	Print Name	Date