Waiver of Group Health Benefits & Notice of Special Enrollment Rights

(Employer Name)		
Please complete the following:		
Employee Name:		
(Last)	(First)	(MI)
Employee Number:(ID, Social Security or employee #)		
For the plan year effective//_ I am waiving cove (MM/DD/YY) Myself Spouse/Domestic Partner Dependent (s) – Please list names:	age for:	
I am waiving coverage due to:		
My preference not to have coverage		
Coverage under my spouse's/domestic partner's plan – name of carrier:		
Other coverage – name of carrier:		
	☐ Medicare ☐TRICARE (formerly 0-Sponsored Group Plan	CHAMPUS)
Special Enrollment Notice and Certification – Please review and sign below if you wish to waive coverage		
By signing below, I certify that I have been given an opporteligible dependents, if any. I am declining enrollment as in enrollment for myself or my eligible dependents (including group health plan coverage, I may be able to enroll myself my eligible dependents lose, eligibility for that other coverage or my eligible dependents' other coverage).	ndicated above. I understand that I am omegate my spouse) because of other health instand my eligible dependents in this plan	declining surance or n if I lose, or

I understand that I must request enrollment no more than 30 days after the date the other health plan coverage ends (or after the employer stops contributing toward the other coverage). If I do not do so, I will not be able to enroll until my employer's next annual open enrollment period.

In addition, I understand that if I have a newly eligible dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my eligible dependent(s). However, I must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

I understand that in order to request special enrollment or obtain more information, I should contact my group administrator.

Signature of Employee

Date of Signature