WAIVER FORM

Name of Employee: ____
(Please print clearly)

Name of Employer: ____

Number of Hours Worked Per Week: _____________ Date of Hire: __________

Reason for Waiver of Health Coverage (Please check one):

Waivers not affecting participation requirements

- ❑ Spousal Waiver
  (coverage through spouse's health plan)
- ❑ Parental Coverage Waiver
  (coverage through parent's health plan)
- ❑ Medicare Waiver
  (coverage through Medicare)
- ❑ Medicaid Waiver
  (coverage through Medicaid)
- ❑ Other Retiree Coverage
  (coverage through another plan or spouse's plan)
- ❑ Domestic Partner
  (coverage through domestic partner's health care plan)
- ❑ TriCare (Military Health Insurance — formerly Champus)

Waivers affecting participation requirements

- ❑ No Coverage Waiver
  (declining coverage)
- ❑ **Individual Health Plan**
- ❑ Veterans Administration Coverage
  (medical services provided by Veterans Administration)
- ❑ Other ____

I understand that if I and/or my dependents decline coverage and desire to participate in the plan at a later date, evidence of insurability satisfactory to the insurance company must be furnished. Enrollment will be limited to the open enrollment period or anytime there is a qualifying event.

____ ____________________

Signature of Employee Date

Coverage is provided by and services are administered as follows: In Connecticut: Group HMO and POS coverage, and Individual HMO is underwritten by ConnectiCare, Inc. In Massachusetts: Group HMO and POS is underwritten by ConnectiCare of Massachusetts, Inc. PPO coverage, ASO/Self-funded services, and Dental products are administered or underwritten by ConnectiCare Insurance Company, Inc.