



Request for Waiver of Coverage

Name of Employee:

Name of Employer:

Number of Hours Worked Per Week:

Date of Hire:

I decline to enroll in the health plan offered by my employer for the following reason:

(Please check one)

Existence of Other Coverage

Coverage Not Desired

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

Signature of Employee:

Date:

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