MEDICAL COVERAGE WAIVER

(Please complete ONLY if you're waiving medical benefits.)

PLEASE FILL OUT THE ENTIRE APPLICATION TO AVOID PROCESSING DELAY.

Applicant Social Security Number: _____ - _____ - _____ Group No.: _____

Employer Name: _____

Division and/or Location: _____

APPLICANT

Last Name: _____ First Name: _____ Middle Initial: _____

Gender: ❑ Male ❑ Female Marital Status: ❑ Single ❑ Married Date of Birth: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Email Address: _____

Date Employed Full Time: _____ Average Hours Worked per Week: _____

I waive medical coverage for: ❑ Self (and Dependents) ❑ Spouse ❑ Dependents

Please state reason for waiving coverage:

❑ 1. Covered under my spouse/parent employer's group plan

❑ 2. Federal Employees Health Benefits program

❑ 3. Military Service

❑ 4. Covered under individual policy

❑ 5. Medicare/Medicaid

❑ 6. Not interested, and have no other coverage

_____ *(Please Initial)* I understand any future requests for coverage will be allowed only during the open enrollment period occurring 91-60 days prior to the anniversary date of this group plan with coverage effective on that anniversary date.

If I have waived coverage for myself and/or my dependents (including my spouse) because of other health insurance coverage, I may in the future be able to enroll myself and/or my dependents in this plan as a late enrollee. As a late enrollee I am subject to open enrollment provisions of the plan unless I qualify for special enrollment as a result of a qualifying event (involuntary loss of coverage due to divorce, death, legal separation, termination of employment, reduction in number of hours of employment) provided that I request enrollment within 31 days after the date of the event. In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents, provided that I request enrollment within 31 days after the date of the event.

Applicant Signature: _____ **Date:** _____