



# 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: \_\_\_\_\_