



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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