ConnectiCare

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