



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

Coverage is provided by and services are administered as follows: In Connecticut: Group HMO and POS coverage, and Individual HMO coverage is underwritten by ConnectiCare, Inc.; Group coverage for coinsurance plans and Individual POS coverage is underwritten by ConnectiCare Insurance Company, Inc. In Massachusetts: Group HMO and POS coverage is underwritten by ConnectiCare of Massachusetts, Inc. FlexPOS, PPO coverage, ASO/Self-funded services, and Dental products are administered or underwritten by ConnectiCare Insurance Company, Inc.