



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

**Spouse Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_