Metro Atlanta Financial Group

Group number: _____ Requested Effective Date: _____/_____/_____

Waiver of Group Health Benefits and Notice of Special Enrollment Rights

Instructions: Please complete boxes outlined in **RED**.

Please complete the following:

Employer Name:_____

Employee Name:

Last Name: _____ Middle Inittial: _____ First Name: _____

Social Security Number: _____

For the plan year effective: ___/___/_____

I am waiving coverage for (check all that apply):

- ☐ Myself
- ☐ Spouse/Domestic Partner
- ☐ Dependent(s)- Please list names: _____

_____

I am waiving coverage due to:

- ◯ My preference not to have coverage
- ◯ Coverage under my spouse's/domestic partner's plan- name of carrier: _____
- ◯ Other coverage - name of carrier: _____

This other coverage is:

- ◯ Individual
- ◯ TRICARE
- ◯ COBRA
- ◯ Medicaid
- ◯ Medicare
- ◯ Employer-Sponsered Group Plan

Special Enrollment Notice and Certification

By signing below, I certify that I have been given an opportunity to apply for coverage for myself and my eligible dependents, if any. I am declining enrollment as indicated above. I understand that I am declining enrollment for myself of my eligible dependents (including my spouse) because of other health insurance, or group health plan coverage. I may be able to enroll myself and my eligible dependents in this plan if I lose, or my eligible dependents lose, eligibility for that other coverage (or if the employer stops contributing towards my or eligible dependents' other coverage).

I understand that I must request enrollment no more than 30 days after the date the other health plan coverage ends (or after the employer stops contributing towards the other coverage). If I do not do so, I will not be able to enroll until my employer's next annual open enrollment period. In addition, I understand that if I have a newly eligible dependent as a result of my marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my eligible dependent(s). However, I must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

I understand that in order to request special enrollment or obtain more information, I should contact my group administrator.

Signature of Employee: **X** _____

Signature Date: ___/___/_____