Group number: _____

ACTION EXPEDITING

# Waiver of Group Health Benefits and Notice of Special Enrollment Rights

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

## A: Please Complete the Following

Employer Name:

Employee Name:

Last Name: Middle Initial: 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 waving 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 ○ COBRA ○ Medicare ○ TRICARE ○ Medicaid ○ Employer-Sponsored Group Plan

## B: 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 dependent(s), if any. I am declining enrollment as indicated above. I understand that I am declining enrollment for myself and/or my eligible dependent(s) (including my spouse) because of other health insurance, or group health plan coverage, I may be able to enroll myself and my eligible dependent(s) in this plan if I lose, or my eligible dependent(s) 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(s) as a result of my marriage, birth, adoption, or placement of 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: Signature Date: __/__/____