

## Waiver of Group Coverage

Company Name: \_\_\_\_\_

Employee Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### Please Check All That Apply:

- I waive my employer's group **health** insurance coverage for myself and my dependents (if any).
- I waive my employer's group **dental** insurance coverage for myself and my dependents (if any).

### Reason for Waiving Coverage - Please Check One:

- Covered through spouse's employer                       Covered through a parent's employer
- Under 65 Retiree covered by previous employer's insurance program
- Other      Please specify: \_\_\_\_\_

### Please Read and Sign Below:

In waiving coverage, I understand that I and/or my dependents may enroll under this plan in the future only as the result of certain qualifying conditions. For example,

- Within 30 days of involuntarily loss of other group coverage
- At the time of my employer's open enrollment.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_