WAIVER OF HEALTH CARE COVERAGE

DECLINING COVERAGE: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth or adoption, or placement for adoption.

I hereby certify that I have been given an opportunity for health care coverage under the Benefit Plan(s) provided through my employer. I understand the benefits available under the Plan, and I decline to cover:

☐ Myself ☐ My Spouse ☐ My Children ☐ All

I am declining the following coverage:

☐ Medical ☐ Dental ☐ Vision ☐ Life Insurance

☐ Long Term Disability ☐ Other ________________________________

Because ____

____

____

Name ____ Date ___________
(print name)

Signature ______________________________________

Employee ID #____________________________________

Human Resources Internal Use:
cc: Finance Benefits Coordinator ☐
cc: Lifewise ☐
cc: Benefit Providers, if applicable ☐

Medical Waived HL Entry ☐
Deduction Adjustment ☐