



Waiver of Group Health Benefits

Employee Name

Job Title

Employee Number (ID, Social Security, etc.)

For the plan year effective 2025 I am waiving coverage for:

Myself Spouse/Domestic Partner Dependent(s):

If selecting Dependent(s), please list their name(s):

I am waiving coverage for the following reason:

- Coverage does not meet my needs.
- I do not want to be insured.
- I am participating in domestic partner's plan.
- I am participating my parent's plan.
- I plan to participate in the State Exchange Plan.
- I am participating in my spouse's plan.
- I am participating in the State Exchange Plan.
- Too expensive.
- Other coverage: Check one below:
 - Employer-sponsored Group Plan
 - Individual policy
 - Medicare
 - COBRA
 - TRICARE
 - Medicaid

Special Enrollment Notice and Certification – *Please review and sign below if you wish to waive coverage*

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, if I am declining enrollment for myself or 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 my 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 toward 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 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.

Employee Signature

Date