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Medical Waiver Form

Use this form only if you are waiving all lines of coverage.
This form cannot be used to terminate existing coverage.

Group Name			Group Number	
Hire Date (MM/DD/YYYY)			Benefit Class ❑ COBRA ❑ Eligible ❑ Ineligible	
Prefix First Name		Middle Initial	Last Name	Suffix
Social Security #			Date of Birth (MM/DD/YYYY)	
Gender ❑ Male ❑ Female		Marital Status	❑ Divorced ❑ Legally Separated ❑ Single ❑ Married ❑ Domestic Partner ❑ Widowed	
Address		Apt.	City/State/Zip	
Work Phone			Work Email	

Reason for waiving coverage:
I have other coverage from:

❑ Spousal Coverage ❑ Medicare ❑ Medicaid ❑ Veteran's Administration ❑ Parental Waiver

❑ Another source of coverage (please specify)_____

Name of carrier_____Policy Number_____

❑ Other reason for waiving coverage (please explain)_____

I certify that all information provided on this form is true and complete. By refusing group medical enrollment, I acknowledge that I and/or my dependent(s) may have to wait until the plan's next open enrollment or have a qualifying event to enroll.

Employee Signature_____ Date_____

Authorized Signature_____ Date_____