

Medical Coverage Waiver Form

Section 1: Employee Information Employee Name: Group Name: Date of Birth: (MM/DD/YYYY) Employee Social Security Number: Average # of Hours Worked Per Week: **Section 2: Reason for Refusal** I have had the medical benefits program presented to me for my participation and I have elected to decline coverage for the following reason: Please check one: Covered by spouse's insurance program* Covered under parent's plan (note - up to age 26)* Covered under a separate employer, union, or retiree plan* Covered by either Medicare or Medicaid* I simply do not desire to participate in the plan Covered by individual policy* *Please provide name of carrier and policy number **Section 3: Employee Signature** I understand that by declining coverage at this time, I will not be eligible to elect medical coverage until the next annual open enrollment of the group's policy, or if a qualifying event occurs.

Date

Signature