



# Small Group Waiver of Coverage

Complete this form if you do not want to enroll for coverage for yourself and/or your dependents.

Employer Name
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Employee Name	Date of Birth	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	
Social Security Number	Date of Hire	Number of hours worked each week	<input type="checkbox"/> Widowed	<input type="checkbox"/> Legally Separated	
			<input type="checkbox"/> Full-time	<input type="checkbox"/> 1099	<input type="checkbox"/> Seasonal
			<input type="checkbox"/> Part-time	<input type="checkbox"/> Retired	<input type="checkbox"/> Temporary

I understand I am eligible to apply for this coverage through my employer; however, I am waiving coverage as noted below.

	<i>Benefits waiving – check all that apply</i>	<i>Reason for declining coverage</i> <i>Attach a copy of the front/back of your health ID card:</i>
<input type="checkbox"/> Employee	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life <input type="checkbox"/> Disability	<input type="checkbox"/> Spouse's group coverage <input type="checkbox"/> Medicare <input type="checkbox"/> CHAMPUS/VA <input type="checkbox"/> Individual <input type="checkbox"/> COBRA <input type="checkbox"/> Retiree <input type="checkbox"/> Other _____ <input type="checkbox"/> Don't want <input type="checkbox"/> Tricare  Carrier Name: _____ ID number: _____

<input type="checkbox"/> Spouse	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	<input type="checkbox"/> Employer's group coverage <input type="checkbox"/> Medicare <input type="checkbox"/> CHAMPUS/VA <input type="checkbox"/> Individual <input type="checkbox"/> COBRA <input type="checkbox"/> Retiree <input type="checkbox"/> Other _____ <input type="checkbox"/> Don't want <input type="checkbox"/> Tricare  Carrier Name: _____ ID number: _____
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<input type="checkbox"/> Children	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	<input type="checkbox"/> Parent's group coverage <input type="checkbox"/> Medicare <input type="checkbox"/> CHAMPUS/VA <input type="checkbox"/> Individual <input type="checkbox"/> COBRA <input type="checkbox"/> Retiree <input type="checkbox"/> Other _____ <input type="checkbox"/> Don't want <input type="checkbox"/> Tricare  Carrier Name: _____ ID number: _____
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I certify I have been given the right to apply for this coverage, however, I am waiving coverage as noted above. By waiving current coverage, I acknowledge that myself and/or my dependents may have to wait until the plan's next anniversary date to be enrolled for group coverage. Pre-existing conditions, when enrolled in this plan, may not be covered for twelve months.

**Sign here ONLY if you are declining coverage for yourself and/or dependent(s)**

**Employee Signature** \_\_\_\_\_

**Date** \_\_\_\_\_