



**Employee's Information**

Last Name		First Name		Middle Initial
Mailing Address				
City	State	ZIP	Social Security Number	
Employer's Name			Date of Hire	

**NOTE:** Employees of Small Group Employers (under 50 employees) are not required to provide a reason for declining Group Coverage but the participation requirements of the Small Group may be affected.

**Persons Declining Coverage**

Last Name	First Name, MI	Date of Birth	Relationship to Employee (self, spouse/dependent, son, daughter)	Do you have coverage under another health insurance policy as the reason for waiving coverage? (please circle one)
				Yes or No
				Yes or No
				Yes or No
				Yes or No
				Yes or No

**Notice of Special Enrollment Rights**

If you are declining enrollment for yourself or your dependents (including your spouse/dependent) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan or if you or your dependents lose eligibility for other coverage (or if the employer stops contributing towards you or your dependents' other coverage). However, you must request enrollment within 31 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent, as a result of marriage, birth, adoption, or placement for adoption, you may be eligible to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

**Employees Acknowledgement and Signature**

I, on behalf of all persons listed above as waiving coverage (hereafter, "Person Waiving Coverage"), acknowledge that any Person Waiving Coverage is declining coverage without inducement or pressure by my employer or the insurer. I understand that any Person Waiving Coverage who later wants to participate in the plan, will not be able to enroll until the next open enrollment period, unless the plan is a small employer's plan (in which case, a Person Waiving Coverage may apply at any time, but he/she will be subject to an 18-month pre-existing condition exclusion period). I also understand that if a Person Waiving Coverage loses his/her other coverage as a result of termination of employment, cessation of employer contributions, exhaustion of COBRA continuation coverage or other involuntary loss of eligibility, the Person Waiving Coverage will have a special enrollment right. The Person Waiving Coverage also has a special enrollment right in the event of marriage or a child's birth, adoption or placement for adoption. I understand that, to use a special enrollment right, a Person Waiving Coverage must submit an enrollment form within 31 days from the occurrence of the special enrollment event.

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

\_\_\_\_\_  
Date