EMPLOYER GROUP HEALTH PLAN
WAIVER OF COVERAGE

EMPLOYER GROUP NAME: _____

MUST BE COMPLETED IN ALL CASES WHEN WAIVING COVERAGE

After careful consideration, and despite my employer's contribution towards coverage, I hereby elect to waive coverage provided by my employer on behalf of: (***check all that apply***)

_____ Myself (the employee) _____ My Spouse _____ My Child(ren)

I, my spouse and/or my children are covered by an:

_____ Individual Policy issued by _____
(Name of Insurance Company)

_____ Group Policy _____ issued by _____
(Group Policy No.) (Insurance Company)

_____ Prepaid Policy issued by _____
(Name of Insurance Company)

_____ Federal or State Government Policy _____
(Policy No.)

_____ Other (Provide Explanation) _____

_____ I am not interested in carrying health care coverage.

I understand that this action constitutes forfeiture of group benefits provided by my employer for me (the employee), my spouse and/or my spouse and children. In order for me (the employee) my spouse and/or my spouse and children to be insured under the Group Benefit program provided by my employer in the future, evidence of insurability - including physical examination, when requested, at my (the employee) expense may need to be provided on each applicant.

_____
(Employee Signature) (Date)

_____
(Print Name)