

## BENEFIT DESIGN GROUP

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### WAIVER OF EMPLOYEE GROUP INSURANCE

Please explain your reason(s) for declining coverage under you Company's Group Plan

COMPANY NAME	ACCOUNT NUMBER/GROUP NUMBER
EMPLOYEE NAME	SOCIAL SECURITY NUMBER
DATE OF HIRE	DATE OF BIRTH

### REASON FOR WAIVER OF COVERAGE

You are required to state the reason(s) why you and/or your eligible dependents have declined coverage under the Company's group Plan.

Spouse's group health benefit plan or employer-sponsored plan	Spouse's employer: Spouse's insurance carrier: Membership No.
Individual (non group) Health Benefit Plan (including Medicare, Medicaid, and Champus)	Insurance carrier:
Another group health plan offered through my employer	Insurance carrier:
COBRA Continuation coverage	My Current employer My Previous employer
Medicare, Medicaid or Champus through another employer.	
Enrolled in another type of Insurance plan or arrangement	Specify:
Declining my employer's group health benefit plan even though I currently have no other coverage.	

I hereby certify that the medical benefits provided by my Employer have been explained to me; that I have been given an opportunity to apply for Plan coverage; and that I voluntarily decline to participate in the Plan due to the reason(s) stated above.

I understand that I am required by my Employer to complete and sign this statement. If this statement has been completed and if the reason for declining coverage is because of other health benefit coverage which is later lost, or exhausted in the case of COBRA coverage, I may enroll for coverage under this plan and the effective date will be the date the prior coverage was terminated or exhausted as long as I enroll within 31 days of the date of termination or exhaustion. If this statement has not been completed and if I do not enroll within the 31 day timeframe, then I understand that I must wait until the next open enrollment period to enroll.

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Employee Signature

Date