HEALTH BENEFIT WAIVER FORM

I have been provided an opportunity to review a complete description of the company's health insurance plan. This review included the plan's coverage, eligibility, enrollment restrictions, and costs.

At this time, I choose to **WAIVE COVERAGE** and **NOT** enroll.

Please initial the following sections that apply:

Initial	I do not wish to request coverage under the group plan(s) at this time.
Initial	I understand that I am waiving coverage for myself and/or my eligible dependents as I/we are currently covered under another health benefit plan. I further understand that by waiving coverage at this time said plan may impose (should I/we later decide to apply for coverage under this plan) an exclusion from coverage for a period of time specified by the plan or until the next open enrollment period. I also understand that late enrollment in this plan may allow for an additional exclusion for any pre-existing condition, if this provision is included in the plan.

Name of person maintaining coverage:

Employer:

Provider of Coverage:

Policy ID #:

Coverage Status: ☐ Single ☐ Family

Employee Name:	Witness:
Employee Signature:	Witness Signature:
Date:	Date: