



MEDICAL COVERAGE WAIVER FORM

Name: _____

Social Security Number: _____

I have had the medical benefits program for the employees of _____
Presented to me for my participation and I have elected to decline coverage for the following
reason:

- Covered by spouse's insurance program. Plan Name: _____
- Covered as Student under Parent's plan. Plan Name: _____
- Covered under another employer plan. Plan Name: _____
- Covered by Medicare Supplement. Plan Name: _____
- Covered by retiree plan from former employer. Plan Name: _____
- I simply do not desire to participate in plan. _____

I further understand that by declining coverage at this time, I will not be eligible to elect medical coverage until the next anniversary date of policy or if a qualifying event occurs, I will become eligible within 30 days of the event.

Date

Signature

- I have not met the length of employment requirements to be eligible, but will be participating when eligible. Date of Hire: _____

Date

Signature