



I am planning to waive my medical coverage.

I acknowledge I have been given the opportunity to apply for group coverage available to me and my dependents through my employer; however, I am electing not to enroll. By declining the group coverage, I acknowledge that I and/or my dependents may have to wait until the plan's next anniversary date to be enrolled for group coverage.

I wish to decline medical coverage for:

- ☐ Myself ☐ Spouse/domestic partner ☐ Child(ren)

I wish to decline coverage for the following reasons (check one below):

- ☐ I have coverage by spouse/domestic partner's group health plan.
- ☐ I have coverage through a government plan (select one):
- ☐ Medicare ☐ Medicaid ☐ State plan
- ☐ I have an individual medical plan.
- ☐ I do not have and do not want medical coverage.
- ☐ Other (explain): _____

Employee signature: _____

Date: _____