

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:

Spouse/domestic partner

Child(ren)

Geisinger Health Plan

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: _____

Myself

Date: ___

Geisinger Health Plan may refer collectively to Geisinger Health Plan, Geisinger Quality Options, Inc., and Geisinger Indemnity Insurance Company, unless otherwise noted. Services provided by Geisinger Indemnity Insurance Company.

HPM50 ab Employee coverage waiver Dev. 11/2019