

Geisinger

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 name (print):
Employee signature:
Date:

Geisinger Health Plan may refer collectively to health care coverage sponsors Geisinger Health Plan, Geisinger Quality Options, Inc., and Geisinger Indemnity Insurance Company, unless otherwise noted. Geisinger Health Plan is part of Geisinger, an integrated health care delivery and coverage organization. HPM50 kf Employer coverage waiver form Rev. 7/20