





## HEALTH COVERAGE WAIVER FORM

**(Complete Waiver only if you are waiving coverage for yourself and / or any dependent)**

<b>GROUP / EMPLOYER NAME:</b>	<b>GROUP NUMBER</b>
<b>EMPLOYEE NAME:</b> (LAST)                      (FIRST)                      (INITIAL)	<b>SOCIAL SECURITY NUMBER</b>

**I decline to enroll in health coverage for:**

- |  |                                    |                    |  |
|--|------------------------------------|--------------------|--|
| <input type="checkbox"/> Myself                                    | <input type="checkbox"/> My Spouse | Reason for waiver: | <input type="checkbox"/> the existence of other coverage |
| <input type="checkbox"/> My Dependent Child/Children (please list) |                                    |                    | <input type="checkbox"/> other reason (explain) _____    |

- |          |          |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

I understand that this waiver of coverage may affect the ability of each person listed above to obtain coverage at a later date. Specifically, except during applicable "Special Enrollment Periods", each person listed above may be considered to be a Late Enrollee, and subjected to an exclusionary period of up to eighteen (18) months [12 months for Oregon domiciled employers, 3 months for Washington domiciled employers with 51 or more employees, 9 months for Washington domiciled employers with less than 51 employees] for any pre-existing condition, as that term is defined by Federal Law (HIPAA).

EMPLOYEE'S SIGNATURE \_\_\_\_\_

DATE SIGNED \_\_\_\_\_

SPOUSE'S SIGNATURE \_\_\_\_\_  
(If Spouse is waiving coverage)

DATE SIGNED \_\_\_\_\_