

# Waiver of Group Health Benefits & Notice of Special Enrollment Rights

Employee Name: \_\_\_\_\_  
(Last) (First) (MI)

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**I have been informed that I am eligible to apply for health coverage under the S.W. Rodgers Health Plan.**

For the plan year effective \_\_\_\_ / \_\_\_\_ / \_\_\_\_, I am waiving coverage for:

- Myself  
 Spouse  
 Eligible Dependent(s) – Please list names: \_\_\_\_\_

**I am waiving coverage due to:**

- My preference not to have coverage  
 Coverage through my spouse's employer – name of carrier: \_\_\_\_\_  
 Other coverage:  Individual  COBRA  Medicare  Medicaid  
 TRICARE (formerly Champus)  Employer-Sponsored Group Plan

By signing below, I certify that I have been given an opportunity to apply for coverage for myself and my eligible dependents, if any. I am declining enrollment as indicated above. I understand that I am declining enrollment for myself or my eligible dependents (including my spouse) because of other health insurance or group health plan coverage. I may be able to enroll myself and my eligible dependents in this plan if I lose, or my eligible dependents lose, eligibility for that other coverage (or if the employer stops contributing towards my or my eligible dependent's other coverage).

I understand that I must request enrollment no more than 30 days after the date the other health plan coverage ends (or after the employer stops contributing towards my or my eligible dependent's other coverage). If I do not do so, I will not be able to enroll until my employer's next annual open enrollment period.

In addition, I understand that if I have a newly eligible dependent as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my eligible dependent(s). However, I must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

I understand that in order to request special enrollment or obtain more information, I should contain my group benefits administrator.

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date