

WAIVER OF GROUP COVERAGE

(MUST BE COMPLETED IF ANY COVERAGE IS DECLINED OR REFUSED BY AN ELIGIBLE EMPLOYEE)

EMPLOYEE NAME _____

SOCIAL SECURITY # _____

EMPLOYER NAME _____

I WAIVE TOTAL COVERAGE FOR MYSELF
(AND DEPENDENTS, IF ANY)

I WAIVE HEALTH PLAN COVERAGE FOR MYSELF
(AND DEPENDENTS, IF ANY)

I WAIVE HEALTH PLAN COVERAGE FOR MY SPOUSE ONLY

I WAIVE HEALTH PLAN COVERAGE FOR MY CHILDREN ONLY

REASON FOR DECLINING COVERAGE (CHECK ONE):

COVERED BY SPOUSE'S COVERAGE

COVERED BY CHAMPUS OR CHAMPVA

COVERED BY HMO

OTHER (EXPLAIN) _____

THIS IS TO ACKNOWLEDGE THAT THE AVAILABLE COVERAGES HAVE BEEN EXPLAINED TO ME BY MY EMPLOYER. I HAVE BEEN GIVEN THE OPPORTUNITY TO APPLY FOR THE AVAILABLE COVERAGES AND HAVE ELECTED NOT TO ENROLL MYSELF AND/OR MY DEPENDENTS, IF ANY.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if employer contributions towards your or your dependent's other coverage terminate) provided that you request enrollment within 31 days after your coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself or your dependents, provided that you request enrollment within 31 days (60 days in Idaho) after the marriage, birth, adoption or placement for adoption. To request such special enrollment, please contact Kay Harrison, Enrollment Department, (801) 263-8000 x104 or (800) 748-5340 x104.

EMPLOYEE SIGNATURE

DATE