EMPLOYEE INFORMATION

Employer Name: _____

Employee name: _____ Employee date of birth: _____

☐ Male ☐ Female Employee Date of Hire: _____ Number of hours worked per week: _____

Employee Mailing Address:_____City: _____ State: _____ Zip: _____

Employee social security number: _____ Employee date of hire: _____

WAIVER CONFIRMATION
This is to confirm that I decline to participate in my employer's group health plan as follows.

I do not wish to enroll **myself**. I have other insurance coverage through:
☐ CHAMPUS/Tricare
☐ Medicare as primary, at the request of the Medicare enrollee
☐ Another group health plan through my spouse or parent. Name of spouse's/parent's employer:
_____.

☐ I do not wish to enroll **myself**. I have other Individual insurance coverage.
☐ I do not wish to enroll **myself**. I do not have other health coverage.

EVIDENCE OF OTHER GROUP COVERAGE (please provide Human Resources with the following)
Copy of your insurance ID card from the other group coverage

EMPLOYEE SIGNATURE
If you are declining enrollment because of other health care coverage, you may in the future enroll yourself or your dependents in this plan prior to the next open enrollment period. To do this, you must have involuntarily lost your other coverage and we must receive your enrollment application within 30 days after your other coverage ended (60 days if the prior coverage was through Medicaid or CHIP). Additionally, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and dependents, provided we receive your completed enrollment application within 60 days after the marriage, birth, adoption, or placement for adoption, unless a different time limit has been specified in your benefit booklet.

By signing below, you understand that you will be unable to obtain coverage under your employer's group health plan until the next open enrollment period, unless you and/or your dependents qualify for enrollment under the special enrollment rules described above.

NOTE: Your employer's medical insurance plan meets the "minimum value" standard per the Affordable Care Act.

Please note: *It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.*

Employee Signature X _____ Date: _____

Fax to BSI at 425-771-1226