Excellus

Waiver of Group Coverage

Company Name: _____

Employee Name: _____ Date of Birth: _____

Please Check All That Apply:

[ ] I waive my employer's group **health** insurance coverage for myself and my dependents (if any).

[ ] I waive my employer's group **dental** insurance coverage for myself and my dependents (if any).

I, _____ (print name), acknowledge that I have been apprised of my right to receive health insurance coverage in compliance with the provisions of the Patient Protection and Affordable Care Act. I knowingly and voluntarily agree to waive my right to receive health insurance from the District.

Reason for Waiving Coverage - Please Check One:

[ ] Covered through spouse's employer [ ] Covered through a parent's employer

[ ] Under 65 Retiree covered by previous employer's insurance program

[ ] Other Please specify: _____

Please Read and Sign Below:

In waiving coverage, I understand that I and/or my dependents may enroll under this plan in the future only as the result of certain qualifying conditions. For example,

- Within 30 days of involuntarily loss of other group coverage
- At the time of my employer's open enrollment.

Employee Signature: _____ Date: _____

Creation Date: 10/30/2009
Revision Date: 10/16/2013