Waiver of Coverage & Verification of Alternative Coverage

Employee Information

Employer Company Name: _____

Employee Name:_____ Date of Birth: __ /__ /____

Reasons for Waiver

On behalf of myself and my eligible dependents (if any), I waive the option to enroll in the employer-provided health insurance coverage at this time because:

- ☐ I am covered under my spouse's health plan.
- ☐ I am covered under another health plan offered by this employer.
- ☐ I am covered under another group health plan offered by a second employer.
- ☐ I am covered under a non-group, individual or private health care plan NOT offered through my employer.
- ☐ I am covered under my parent's health plan.
- ☐ I am covered by Medicare, MassHealth or a Veterans Program.
- ☐ I live in the town of _____ which is not in the health plan service area.
- ☐ I do not wish to enroll in any type of medical coverage at this time. (I am declining health insurance entirely)
- ☐ Other (must provide details): _____

_____

If you have coverage elsewhere, please provide the following information:

Carrier Name: _____ Subscriber Name: _____

Signature and Attestation

I affirm that the information I have provided on this form is complete and true to the best of my knowledge. I understand that if I choose to enroll at a later date, that I must have a qualifying event and meet the eligibility and enrollment rules at that time. I understand that any material misinformation (including omissions) may result in an inability to obtain insurance through this employer's insurance offering.

Employee Signature: _____ Date Signed: ___ /___ /_____