Waiver of Coverage Form

Company Name: ______________________________

Employee Name: ______________________ Date of Birth __________

☐ **I waive health coverage for myself and dependents (if any).**

Reason for Declining Coverage:

- ☐ I am covered through spouse's employer
- ☐ I am covered through parent's health plan
- ☐ I am 65 or over and covered by Medicare
- ☐ I am covered by MassHealth
- ☐ I am covered by another health plan offered by my company
- ☐ I am covered by another health plan offered by a second employer
- ☐ I am covered by a veterans program
- ☐ I am covered by a non-group health plan
- ☐ I do not wish to participate at this time
- ☐ I live in the town of __________ that is not in the health plan service area
- ☐ Other; please specify: ______________________

Employer Name: ______________________________

Insurance Carrier: ______________________________

______________________________ Employee Signature

______________________ Date

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