

# Waiver of Group Coverage



MASSACHUSETTS

Company Name: \_\_\_\_\_

Employee's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## Please Check One:

- I waive my employer's group health insurance coverage for myself and my dependents (if any).
- I am enrolling in my employer's group health insurance coverage but I am waiving coverage for my dependents.

## Reason for Waiver of Coverage—Please Check One:

- Covered through spouse's employer.

Employer Name: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

- Other reason (explain): \_\_\_\_\_

As a result, I waive my and/or my dependents' (if any) eligibility to enroll in my employer's group plan at this time. I understand that I and/or my dependents may enroll under this plan in the future under the terms defined in the eligibility section of the subscriber certificate or benefit description.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_