SEIU HEALTHCARE NW HEALTH BENEFITS TRUST WAIVER COVERAGE FORM

EMPLOYEE NAME : ______________________________ IPOne # or SSN: ____________________

I have been given the opportunity to enroll myself and eligible dependents, if applicable, in the medical plans sponsored by my employer.

I understand that if I request health care coverage under this plan at a later date for myself or my dependents, if applicable, coverage will be denied except:

1. During the annual open enrollment period in July, or
2. By special enrollment within 60 days of an involuntary loss of healthcare coverage, or
3. By special enrollment within 60 days of a change in household such as a marriage, birth, or adoption.

EMPLOYEE WAIVER

I choose to waive coverage for the reason(s) below:

☐ I have other healthcare coverage

☐ O ther (please specify) ____

By signing this form you are confirming that you are declining to participate in the SEIU Healthcare NW Health Benefits Trust insurance plan.

Signature: ______________________________ **Date** : ____________________

Print Name: ______________________________