SEIU 775 BENEFITS GROUP

Waive 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

☐ Other (please specify) _____

_____

Employee Signature **Date Signed**

_____

Employee Name (please print)