Excellus

Waiver of Group Coverage

Company Name: _____

Employee Name: _____ Date of Birth: _____

Health Plan (Product) Effective Date: _____

Please Check All That Apply:

[ ] I waive my employer's group **health** insurance coverage for myself and my dependents

[ ] I waive my employer's group **dental** insurance coverage for myself and my dependents

Reason for Waiving Coverage - Please Check One:

[ ] Covered through spouse's employer [ ] Covered through a parent's employer

[ ] Under 65 Retiree covered by previous employer's insurance program

[ ] Covered with another carrier through my group (coverage is not on NYS of Health exchange)

[ ] Other Please specify: _____

Please Read and Sign Below:

In waiving coverage, I understand that I and/or my dependents may enroll under this plan in the future only as the result of certain qualifying conditions. For example,

- Within 30 days of involuntarily loss of other group coverage
- At the time of my employer's open enrollment.

Signature: The undersigned certifies that, to the best of my knowledge and belief and under penalty of perjury, the information listed above is true and complete.

Employee Signature: _____ Date: _____