# Benefits Waiver Form

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|---|---|---|
| **Employee Name:** | | |
| *Last* | *First* | *Middle Initial* |
| **Date of Employment:** | | |
| **Date of Birth:** | | |

I was given the opportunity to enroll in a group insurance health plan offered by my employer and insured by ConnectiCare.

**(Note: Benefits provided on a noncontributory basis cannot be funded.)**

I am declining to enroll for the reason shown below:

- ☐ Covered by spouse's group coverage
  Carrier Name and Member ID: _____
- ☐ Enrolled in another Insurance Carrier Plan
  Carrier Name and Member ID: _____
- ☐ Covered by Medicare
- ☐ Other (*Please explain*)_____

I acknowledge I have been given the opportunity to apply for this medical coverage. However, I am electing not to enroll. By declining this group health coverage I acknowledge that I and my dependents (if any) may have to wait until the plan's next anniversary date to enroll for group health coverage.

_____

Employee Signature Date