Request for Waiver of Coverage

Name of Employee: ____

Name of Employer: ____

Number of Hours Worked Per Week: ______________

Date of Hire: ____ /____ /______

I decline to enroll in the health plan offered by my employer for the following reason:
(Please check one)

☐ Existence of Other Coverage

☐ Coverage Not Desired

I understand that if I and/or my dependents decline coverage and desire to participate in the plan at a later date, evidence of eligibility satisfactory to the insurance company must be furnished. Enrollment will be limited to the open enrollment period or anytime there is a qualifying event. I the undersigned have been offered and declined coverage.

______________________________________	____________________
Signature of Employee	Date

Coverage is provided by and services are administered as follows: In Connecticut: Group HMO and POS coverage. In Massachusetts: Group HMO and POS is underwritten by ConnectiCare of Massachusetts, Inc. PPO coverage, ASO/Self-funded services, and Dental products are administered or underwritten by ConnectiCare Insurance Company, Inc.