



CT Health Care Coverage Waiver Form

Employer Company Name: Empire Property Management

Employee Name: _____

On behalf of myself and my eligible dependents (if any), I waive the option to enroll in Harvard Pilgrim Health Care health insurance offered at this time by or through my employer for the following reason:

- I am covered under another plan as a spouse or dependant
- I am covered by Medicare, Medicaid or a Military program
- I am covered under another plan sponsored by a second employer

For each person declining to enroll in Harvard Pilgrim at this time because of other health care coverage listed above, please provide the following information:

Subscriber Name: _____

Carrier Name: _____ Group/Policy Number: _____

- I am covered by individual or non-group health plan provided through the Exchange
- I am covered by individual or non-group health plan not provided through the Exchange
- I am covered by a Veteran’s program or another health plan sponsored by this employer
- I do not wish to participate on health care benefits at this time (I am declining health insurance entirely)

Notice of Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this health plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

I understand that any person choosing to enroll later must meet Harvard Pilgrim’s requirements for eligibility and for late enrollees.

Employee Signature: _____ Date: _____

I affirm that the assertions in this form are true and complete to the best of my knowledge, and I understand that Harvard Pilgrim has the right to terminate coverage, retroactive to the effective date of coverage, for any material misinformation (including omissions) contained in this form.

Employer Signature: _____ Date: _____