

WAIVER FORM

Name of Employee: _____

Name of Employer: _____

Employer Address: _____

Hours Worked: _____ Date of Hire: _____

Social Security Number: _____

Reason for Waiver of Health Coverage (Please check one):

- Spousal Waiver
(coverage through spouse's health plan)
- Parental Coverage Waiver
(coverage through parent's health plan)
- Medicare Waiver
(coverage through Medicare and/or supplemental Medicare plan)
- Medicaid Waiver
(coverage through Medicaid and/or supplemental Medicaid plan)
- Other Retiree Coverage, (name of plan) _____
(coverage through another plan or spouse's plan)
- Domestic Partner
(coverage through domestic partner's health care plan)
- No Coverage Waiver
(electing no coverage at this time because coverage is provided by another source)
- Other _____

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

Signature of Employee

Date

ConnectiCare, Inc.

ConnectiCare of Massachusetts, Inc.

One of America's highest-rated health plans