SEVENTH-DAY ADVENTIST CHURCH

Health Insurance Waiver Form

A. I would like to decline coverage for: (Check one)
□ Employee □ Spouse □ Dependent Children □ Spouse and children

B. Reason for declining coverage: (Check one)

□ Covered by spouse's group coverage – Carrier name and I.D. number:_____

□ Enrolled in any other insurance carrier plan – Carrier name:_____

□ Military

□ Medicare

□ Other (Explain):_____

I acknowledge that the available coverage has been explained to me by my employer and I understand that I have every right to apply for coverage. I have been provided the opportunity to apply for this coverage and I have declined to enroll myself and/or my dependents(s), if any. I have made this decision voluntarily. **BY DECLINING THIS GROUP HEALTH COVERAGE (UNLESS EMPLOYEE AND/OR DEPENDENTS HAVE GROUP HEALTH COVERAGE ELSEWHERE), I ACKNOWLEDGE IF WE APPLY FOR COVERAGE AFTER OUR ORIGINAL ELIGIBILITY DATE FOR THIS INSURANCE, MY DEPENDENT(S) AND I MAY BE CONSIDERED LATE ENTRANT(S) AND THEREFORE NOT ELIGIBLE UNTIL THE NEXT OPEN ENROLLMENT.**

Employee Signature:_____ Date:_____

Print Employee Name:_____

Social Security #:_____

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