109 Rykowski Lane
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HEALTH BENEFITS WAIVER FORM

Instructions: Please use this form to decline benefit coverage. Not declining a benefit does not mean you will be enrolled in that benefit since you must complete an enrollment form.

Employee Last Name:
Employee First Name:
Employee Middle Initial:
Date of Employment:
Date of Birth:
Group Name:
Group Number:

I was given to opportunity to enroll in a group insurance health plan offered by my employer and insured by Crystal Run Health Plans.

Please check the reason you are declining Medical Coverage at this time:

__Have Coverage through spouse/domestic partner/parent
Health Plan Name: ___________________________________
Member ID Number: __________________________________

__Covered by Medicare

__Covered by Medicaid

__ Qualified Health Plan/Essential Plan Program

__Covered by TRICARE or CHAMPVA

__Have Coverage through another source (indicate source of coverage): ________________________________
Health Plan Name: _____________________________________
Member ID Number: ___________________________________

I acknowledge I have been given the opportunity to apply for this medical coverage. However, I am electing not to enroll at this time. 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.

____

Signature of Employee Date

____

Printed Name