Waiver of Health Insurance Coverage Statement

Employee Information

Name: _____

Employee ID: _____

Department: _____

Waiver Statement

I hereby acknowledge that I have been offered the health insurance coverage provided by my employer. I understand the benefits and coverage options available to me. I voluntarily decline and waive participation in the employer-sponsored health insurance plan at this time.

I confirm that I have other health insurance coverage and assume full responsibility for all medical expenses incurred by myself and my dependents. I understand that I may not be able to enroll in the plan until the next open enrollment period or unless I experience a qualifying life event.

Other Coverage Information

Current Provider: _____

Policy Number: _____

Date: _____

Signature: _____