



Waiver of Medical Coverage

If you are eligible for the group medical coverage offered by your employer and choose not to take it, you must complete the following form:

Employee Name (last, first) _____ Employee SS# _____

Employer Name _____ Control/Suffix/Acct _____

Date of Birth _____ Date of Hire _____

Please check and complete the appropriate statement below:

_____ I have been offered group medical coverage by my employer. I am declining this coverage for myself and my eligible dependents because:

OR

_____ I have been offered group medical coverage by my employer. My fully completed enrollment application is stapled to this form. However, the following eligible dependents are declining this coverage.

Dependent's Full Name

Relationship

Dependent Coverage is being declined because: _____

I understand that by waiving coverage at this time, I and/or my dependents will be excluded from coverage for up to 12 months (or until my plan's open enrollment period). I and/or my dependents will be accepted into the plan with no Evidence of Insurability required. I further understand that it will be my responsibility to notify Aetna (through my employer) when my exclusion period has ended.

I and/or my dependents have made this decision of my/their own accord, with no pressure or coercion from my employer, my employer's agent, or the insurance carrier.

Employee's Signature _____ Date _____