Health Insurance Declination

Employee Name: _____ Date: _____

Position: _____

Employee Union: _____

Last 4 SSN: _____

_____(Initial) I attest that I am declining the group health insurance plan because I am currently enrolled in other group health or insurance coverage. I have attached proof of alternative coverage.

CERTIFICATION:

I, _____, freely and voluntarily waive health insurance coverage.

Note: If you decline benefits for yourself or dependents, you may be able to enroll them in the future pending an open enrollment or "qualifying event" (family status change)

_____ _____

Employee Signature Date

HR USE ONLY

____Employee is eligible for health insurance

____Entered in system

____Employee eligible for payment for insurance declination (Amount: _____)