

**Health Plan Waiver
Eligible Employee and Dependent Waiver**

Group Name/Number: _____

Employee Name: _____

Dependent(s) Name(s): _____

I acknowledge receiving information on enrolling in the Group Health Cooperative of South Central Wisconsin (GHC-SCW) Health Plan and hereby certify that I am waiving medical coverage for the following persons (check as many boxes as appropriate):

- Employee
- Spouse
- Children

The reason I am waiving coverage is:

- Waiving due to other coverage: _____
- Waiving due to no other coverage
- The annualized premium contribution to be paid by me for the GHC-SCW health benefit plan would exceed 10 percent of my annualized gross earnings (If the individual is not enrolled in HIRSP).

Important - Please Read!

If you are waiving/declining medical coverage for yourself and/or your dependents (including your spouse) because of other health coverage, you may in the future be able to enroll yourself and/or your dependents when other coverage ends, provided that you request enrollment within 30 days after your other coverage ends.

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and/or your dependents provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

If you waive/decline medical coverage for yourself and/or your dependents for any other reason, you may be considered a late enrollee and subject to 12-month waiting period **following the 1st of the month after the date the Group Subscriber Application is received at GHC-SCW.**

I proclaim that I was not pressured or forced by the employer named above, the writing agent, or GHC-SCW into waiving the above noted coverage. I freely and voluntarily waive the above noted coverage.

If you fail to complete the form, neither you nor your dependents will be entitled to the special enrollment rights described above

Signature

Print Name

____/____/____
Date