Sample Waiver of Health Coverage Form

ABC Company

Medical Plan Waiver Form

Plan Year Jan. 1, 20XX–Dec. 31, 20XX

Name: _____

Address: _____

_____ I waive coverage through ABC Company's group health plan for the plan year beginning on Jan. 1, 20XX, and ending on Dec. 31, 20XX. This waiver applies to me and my eligible dependents.

I am declining to enroll for the reason shown below:

- Covered by spouse's (or domestic partner's) group coverage
    - Carrier name/member ID: _____
- Enrolled in other group health insurance coverage
    - Carrier name/member ID: _____
- Enrolled in Medicare
- Covered by TRICARE
- Other (Please explain)

  _____

I understand that, by declining health coverage through ABC Company, I authorize participation in the ABC Company Section 125 Cafeteria Plan. By waiving this health coverage for the plan year designated above, I acknowledge that I may be required to wait until the next plan year to enroll for group health coverage. In exchange for my waiver of health coverage, ABC Company will pay me $_____ per pay period (24 pay periods per

plan year) for the plan year of Jan. 1, 20XX, through Dec. 31, 20XX, for a total annual deposit of $_____. I understand that these payments are taxable compensation.

Signed: _____ Date: _____

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