**Health Insurance Waiver Form**

**Employee Information**

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| --- | --- | --- | --- |
| **Employee ID:** |  | **Department:** |  |
| **Department:** |  | **Phone Number:** |  |
| **Email Address:** |  |  |  |

**Waiver of Employer-Sponsored Health Insurance**

I, the undersigned, acknowledge that I have been offered health insurance coverage through my employer’s group health plan. I am choosing to **waive this coverage** for the following reason(s):

☐ I am covered under another employer-sponsored health plan (spouse, parent, etc.)  
☐ I am covered under an individual health insurance plan  
☐ I am covered under a government program (Medicare, Medicaid, TRICARE, etc.)  
☐ I choose not to enroll at this time for personal reasons  
☐ Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Important Notice**

* I understand that by waiving this health insurance coverage, I (and my dependents, if applicable) will not be covered under the employer’s group health plan.
* I understand that I may not be able to enroll until the next open enrollment period unless I qualify for a special enrollment event (e.g., loss of other coverage, marriage, birth/adoption of a child).
* I release my employer from any responsibility for medical expenses incurred by me or my dependents.

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| --- | --- | --- | --- |
| **Employee Signature:** |  | **Date:** |  |
| **Employee HR/ Representative:** |  | **Date:** |  |