

WAIVER FORM

Name of Employee: _____
(Please print clearly)

Name of Employer: _____

Number of Hours Worked Per Week: _____ Date of Hire: _____

Reason for Waiver of Health Coverage (Please check one):

Waivers not affecting participation requirements

- Spousal Waiver
(coverage through spouse's health plan)
- Parental Coverage Waiver
(coverage through parent's health plan)
- Medicare Waiver
(coverage through Medicare)
- Medicaid Waiver
(coverage through Medicaid)
- Other Retiree Coverage
(coverage through another plan or spouse's plan)
- Domestic Partner
(coverage through domestic partner's health care plan)
- TriCare (Military Health Insurance — formerly Champus)

Waivers affecting participation requirements

- No Coverage Waiver
(declining coverage)
- Individual Health Plan
- Veterans Administration Coverage
(medical services provided by Veterans Administration)
- Other _____

I understand that if I and/or my dependents decline coverage and desire to participate in the plan at a later date, evidence of insurability satisfactory to the insurance company must be furnished. Enrollment will be limited to the open enrollment period or anytime there is a qualifying event.

Signature of Employee

Date

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Coverage is provided by and services are administered as follows: In Connecticut: Group HMO and POS coverage, and Individual HMO is underwritten by ConnectiCare, Inc. In Massachusetts: Group HMO and POS is underwritten by ConnectiCare of Massachusetts, Inc. PPO coverage, ASO/Self-funded services, and Dental products are administered or underwritten by ConnectiCare Insurance Company, Inc.