GroupHealth COOPERATIVE

GroupHealth OPTIONS, INC.

Waiver of health insurance coverage

I acknowledge that I have been offered the opportunity to purchase health insurance coverage from Group Health Cooperative or Group Health Options, Inc. for myself and my dependents through my employer. I decline enrollment at this time because:

☐ I have other medical insurance provided by:

Insurance company name _____ Policy no. _____

Through (employer name) _____

☐ I do not wish to enroll myself in any type of medical coverage at this time.

☐ I do not wish to enroll my ☐ spouse ☐ child(ren) in any type of medical coverage at this time.

If you are declining enrollment for yourself or dependents (including your spouse) because of other health care coverage, you may, under certain circumstances, in the future enroll yourself or your dependents in this plan prior to the next open enrollment period. To do this, you must have involuntarily lost your other coverage and we must receive your enrollment application within 30 days after your other coverage ended. Additionally, if you have a new dependents as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and dependents, provided we receive your completed enrollment application within 60 days after the marriage, birth, adoption, or placement for adoption.

Printed name _____

Signature _____ Date _____

Name of employer _____