P.O. Box 30192
Salt Lake City, UT 84130-0192
801-442-5038/800-538-5038
selecthealth.org

Waiver Form Small Employer

Company Name Gooding School District 231 Group# ______

Last Name ______ First ______ Initial ______

Social Security# ______ Date Hired ______

WAIVING MEDICAL COVERAGE INFORMATION

I am waiving medical coverage for:

❑ Myself only ❑ Myself and my dependent(s)

Reason for waiving medical coverage:

❑ I currently have medical coverage elsewhere.

Policyholder's Name ______ Relationship to Policyholder ______

Medical Carrier ______ Subscriber ID# ______ Policy Type ❑ Group ❑ Individual

❑ I do not wish to purchase medical insurance at this time (subject to employer participation requirements.

EMPLOYEE SIGNATURE

I hereby decline to apply for medical coverage in the group health benefit plan provided through my employer. The benefits of the plan have been thoroughly explained to me. I understand that if I waive coverage for myself, my dependent(s) are also not eligible for coverage with SelectHealth.

NOTE: You and/or your dependent(s) may not be eligible for coverage in this program until the next annual open enrollment period. For waiver of medical coverage only, if you do enroll at a later time, you may be subject to an 18-month pre-existing condition waiting period unless you experience a special enrollment event (e.g., involuntary loss of other coverage, marriage, birth, adoption, or placement for adoption). After completing this form, fax it to **801-442-3698**.

Employee's Signature ______ Date ______

© 2012 SelectHealth. All rights reserved. 1878 10/01