Verification Of Alternative Coverage

Employee Name: _____

Social Security Number: _____

Employer Group: _____

I waive my right to participate in XYZ health plan offered at this time by or through my employer because:

- ❒ I am covered under my spouse's health plan.
- ❒ I am covered under another health plan sponsored by my company.
- ❒ I am covered under Medicare.
- ❒ I do not wish to participate at this time.
- ❒ Other: _____

I understand that if I later choose to enroll, I must meet XYZ Health Plan's requirements, if any, applicable to late enrollees.

Name: _____ **Date: _____**

Signature: _____

Special Enrollment Rules:
If you are declining enrollment for yourself or your dependents (including your spouse) because of other health coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.