

Waiver of Group Health Insurance Benefits



EMPLOYER'S NAME (PLEASE PRINT)

EMPLOYEE'S NAME (PLEASE PRINT)

PLEASE CHOOSE THE APPLICABLE OPTION BELOW

I choose to decline enrolling myself and/or my eligible dependent(s) in the group insurance plan(s) indicated below. *

**Please indicate your waiver of coverage by checking all applicable categories and selected family members.*

Group Medical Plan

Exclude My Spouse

Exclude Myself

Exclude My Child(ren)

REASONS FOR DECLINING COVERAGE:

Covered by Spouse's plan

Covered by HMO

Covered by other insurance

Other (Explain)

MEMBERS STATEMENT

I acknowledge that my employer has explained the coverage(s) available.

I have been given the opportunity to enroll in my employer's group medical plan for the coverage(s) and have elected not to enroll myself and/or my dependents, if any.

I understand that I will not be able to enroll in the plan until the next open enrollment period.

MEMBERS SIGNATURE

DATE

All sections of this form must be completed and accompanied by a copy of an itemized bill on provider letterhead to be eligible for plan reimbursement.

**ONLY COMPLETE AND SIGN THIS FORM
IF COVERAGE IS BEING WAIVED**

PLEASE RETURN COMPLETED FORM TO:

Great Bay Administrators, 37 Industrial Drive Exeter, NH 03833,
or submit through our secure portal