

WAIVER OF COVERAGE FORM ID



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If you decline to enroll either yourself or your eligible family members in the health care coverage offered by your employer, we ask that you complete this form. **Qualified late enrollees who decline coverage may not reapply for coverage until their employer's policy renewal date** unless they meet the special enrollment provisions.

EMPLOYEE INFORMATION			
EMPLOYER/GROUP NAME	GROUP NO.	EFFECTIVE DATE OF WAIVER	
EMPLOYEE NAME	SOCIAL SECURITY NO.	EMPLOYEE DATE OF BIRTH	
ADDRESS	CITY	STATE	ZIP
WAIVER INFORMATION – ALL SECTIONS MUST BE COMPLETED			
WHO IS WAIVING COVERAGE			
<input type="checkbox"/> Myself <input type="checkbox"/> My spouse (specify name): _____ <input type="checkbox"/> My children (specify names): _____			
COVERAGE BEING WAIVED			
<input type="checkbox"/> Medical Only <input type="checkbox"/> Medical and Dental <input type="checkbox"/> Dental Only (dental can only be waived if also waiving medical)			
REASON COVERAGE IS BEING DECLINED			
<input type="checkbox"/> I and/or my dependents currently have other qualifying medical coverage through: <i>Insurance Carrier:</i> _____ <i>Policy/Group No.:</i> _____ <i>Group Name:</i> _____ <i>Covered Person's ID No.:</i> _____ <i>Other coverage is:</i> <input type="checkbox"/> Group Policy <input type="checkbox"/> Individual Policy <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Tricare <input type="checkbox"/> Indian Health Service <i>Is your current employer contributing toward this coverage?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other* _____ <input type="checkbox"/> I do not wish coverage and do not have other group coverage* <i>*90% of all eligible employees not otherwise covered by other qualifying medical coverage <u>must</u> enroll in this plan.</i>			
IMPORTANT – PLEASE READ AND SIGN			
I understand that if, at this time, I decline coverage offered by my employer for myself or for any of my eligible family members, and then choose to apply for coverage later, PacificSource may exclude coverage of a pre-existing condition for up to 12 months. However, I, or my eligible dependents, may enroll later if:			
1. We are declining coverage now because we currently have qualifying existing coverage; and 2. We choose to enroll later because of the loss of the existing coverage due to a termination of employment or eligibility or the involuntary termination of the qualifying existing coverage; and 3. I enroll within 31 days after termination of my qualifying existing coverage, or in the case of my dependents, they may take up to 60 days after the loss of their coverage to enroll.			
I understand that if my employer offers more than one plan option, I may switch to another plan at open enrollment. And, credit for time under coverage will be given toward any preexisting condition exclusion period of the other plan.			
I understand that if I receive a court order to provide coverage for my spouse and/or minor dependent child, they may be enrolled as dependents in the first 31 days after issuance of the court order. Coverage will become effective the first of the month following the date of the court order.			
I understand that I can enroll myself, my spouse, and/or any newly acquired dependent children at the time of my marriage. Coverage will become effective the first of the month following marriage. I also understand that if I am enrolled, my newborn child, including an adopted child placed within 60 days of birth, will automatically be covered for the first 60 days of life. However, to extend coverage beyond the initial 60 days, I must enroll the child within the subsequent 60-day period. And, my adopted child placed after more than 60 days after birth may be enrolled within 60 days of placement. Coverage will be effective the date of placement.			
I understand that PacificSource will credit time under qualifying previous coverage toward the preexisting condition exclusion period of my new coverage if the effective date of the new coverage is within 63 days of the of the previous coverage.			
Employee Signature	Date	Spouse Signature	Date