

# WAIVER OF COVERAGE IDAHO



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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, please complete this form. Idaho regulations (IDAPA 18.01.69.046.05) require that we secure a waiver from each person declining coverage.

Group Policy No.	Subgroup No.	Class No. / Classification
<b>EMPLOYEE INFORMATION</b>		
EMPLOYER/GROUP NAME		EFFECTIVE DATE OF WAIVER month_____ day_____ year_____
EMPLOYEE NAME		EMPLOYEE HIRE DATE month_____ day_____ year_____
ADDRESS	CITY STATE ZIP	SOCIAL SECURITY NO.
Date of Birth month_____ day_____ year_____	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Domestic Partner
<b>WAIVER INFORMATION – ALL SECTIONS MUST BE COMPLETED</b>		
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 (required)  <input type="checkbox"/> I and/or my dependents currently have other qualifying medical coverage through: <i>Name of Insurance Carrier:</i> _____ <i>Through:</i> <input type="checkbox"/> My other employer <input type="checkbox"/> My spouse's employer <input type="checkbox"/> My parent's employer <input type="checkbox"/> Individual Policy <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Tricare <input type="checkbox"/> Indian Health Service <input type="checkbox"/> Other (please explain)* _____		
*90% of all eligible employees not otherwise covered by other qualifying medical coverage <u>must</u> enroll in this plan.		
<b>IMPORTANT – PLEASE READ AND SIGN</b>		
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 60 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 the marriage, birth, adoption, or placement for adoption. However, I must request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption. In the case of marriage, coverage will become effective the first of the month following marriage. In the case of birth, adoption, or placement for adoption, coverage will become effective on the date of birth, adoption, or placement for adoption.		
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