WAIVER OF EMPLOYEE AND/OR DEPENDENT HEALTH COVERAGE

_____

Full Name of Employee (Please Print)

My employer has given me an opportunity to apply for group health coverage for myself and my dependents (if applicable). I have declined to apply for coverage as indicated below (Please check the one which applies)

☐ I decline coverage for myself (and my dependents, if any)

REASON FOR DECLINING COVERAGE (**Must check one**)

☐ My preference not to have coverage

☐ Coverage under my spouse's plan—Name of carrier: _____

☐ Other coverage—Name of carrier:_____

***please note: if you are currently enrolled in a plan with NHREC and you wish to cancel that current coverage, please contact the Payroll department, this form does NOT cancel current enrollment.**

I understand that if I decide to apply for health coverage for myself and/ or my dependents at a later date, neither I nor my dependents will be eligible for coverage until my employer's next annual enrollment, unless there is a qualifying event. I understand that at the time I apply for coverage I may be required to furnish at my own expense, evidence of insurability.

_____ _____

Employee Signature in Ink Date