Harvard Pilgrim Health Care

Health Care Coverage Waiver Form

Employer Group Name: _____

Employee Name: _____

On behalf of myself and my eligible dependents (if any), I waive the option to enroll in Harvard Pilgrim Health Care health insurance offered at this time by or through my employer for the following reason:

_____ I am covered under another plan as a spouse or dependent

_____ I am covered under another health plan sponsored by my employer

_____ My eligible dependent(s) is/are covered under another health plan

_____ I do not wish to participate in health care benefits at this time

_____ My eligible dependent(s) do not wish to participate in health care benefits at this time

_____ Other _____

For each person declining to enroll in Harvard Pilgrim at this time because of other health care coverage, please provide the following information:

Name: _____
Carrier Name: _____Group/Policy Number: _____

Name: _____
Carrier Name: _____Group/Policy Number: _____

Notice of Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this health 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.

I understand that any person choosing to enroll later must meet Harvard Pilgrim's requirements for eligibility and for late enrollees.

Employee Signature:_____ Date: _____

I affirm that the assertions in this form are true and complete to the best of my knowledge, and I understand that Harvard Pilgrim has the right to terminate coverage, retroactive to the effective date of coverage, for any material misinformation (including omissions) contained in this form.

Employer Signature: _____ Date: _____