



Waiver of Coverage Confirmation Form

I am electing to waive the medical coverage offered by my employer. I am waiving this coverage because:

- 1) I have medical insurance coverage through**
- spouse/domestic partner
 - parent or guardian.
 - Medicare.
 - Medicaid or other state or federally funded programs.
 - Cobra from previous employer. End date: _____
 - Other (list) _____

Carrier: _____

Effective Date: _____

- 2) I am electing to waive coverage but do not have alternate medical insurance coverage.**

3) Employer: _____

Employee Name (print): _____

Signature: _____

Date: _____