Health Care Coverage Waiver Form

Employer Company 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 group plan as a spouse or dependent

☐ I am covered by Medicare or Veterans Program

☐ I am covered through an Individual plan, or purchased coverage through state or federal exchange

☐ I am covered under another group plan sponsored by a second employer

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

Subscriber Name: _____

Carrier Name: _____ Group/Policy Number: _____

☐ I am covered under another carrier's plan sponsored by this employer

☐ I do not wish to participate in health care benefits at this time (I am declining health insurance entirely)

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: _____

Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care,
Harvard Pilgrim Health Care of New England and HPHC Insurance Company.
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