MercyCare Health Plans™

MercyCare Health Plans
PO Box 550
Janesville, WI 53547
(608) 752-3431 • (800) 895-2421
MercyCareHealthPlans.com

WAIVER FORM

EMPLOYEE INFORMATION

Employee Last Name _____ First Name_____ Middle Initial_____

Social Security Number _____ Birthday (Month/Date/Year) _____ Sex___

Home Address _____ County _____

City _____ State _____ Zip Code _____

Employee's Home Telephone _____

Employer's Name _____Employer Telephone _____

CURRENT MARITAL STATUS (CHECK ONE)

☐ Single ☐Married ☐Widowed ☐Divorced ☐Separated

OTHER HEALTH INSURANCE INFORMATION/COORDINATION OF BENEFITS

Are you or any of your dependents eligible for Medicare Benefits? ☐No ☐Yes

If yes, Name _____

Do you or any dependents have other group medical coverage in addition to this plan? ☐ No ☐ Yes If yes, indicate carrier _____

Did you have prior medical coverage? ☐No ☐Yes If yes, indicate carrier _____

Did dependent (s) have prior medical coverage? ☐No ☐Yes If yes, indicate dependent (s) _____

Carrier _____ Phone # _____Policy # _____

Effective Date _____ Term Date _____

WAIVER OF COVERAGE

I understand that I am eligible to apply for group health insurance through my employer. I do **NOT** want, and hereby waive, group health insurance for (check box that applies) :

☐ Waiving for myself ☐ Waiving for my spouse ☐ Waiving for my dependent child (ren) ☐ Waiving for myself and family

I am waiving group health insurance because (check all that apply):

☐ I, the employee, am covered or will be covered under another plan that is not sponsored by my employer. If currently covered, please attach a copy of your identification card for that plan.

☐ My spouse is covered or will be covered under another plan that is not sponsored by this employer. If currently covered, please attach a copy of your spouse's identification card for that plan.

☐ My dependent child (ren) is covered or will be covered under another plan that is not sponsored by my employer. If currently covered, please attach your identification card for that plan. Please list the name (s) of the child (ren) for whom coverage is being waived.

☐ Other reason (Please provide a written reason for waiving coverage): _____

_____

_____

I certify that I have been given the opportunity to apply for group health insurance and decline to enroll as indicated above, on behalf of myself, my spouse and my dependent child (ren). I understand that by signing this waiver, I, my spouse, and my dependent child (ren) forfeit the right to coverage. I was not pressured, forced or unfairly induced by my employer, the agent or the insurer (s) into waiving or declining the group health insurance. If, in the future, I apply for coverage, I, my spouse, or any of my dependent child (ren) may be treated as a late enrollee and subject to postponement or an exclusion of coverage for preexisting conditions for up to 18 months. This period may be offset by the time I, my spouse or dependent child (ren) was covered under a qualified health plan.

I understand that if I am declining enrollment for myself, my spouse, or my dependent child (ren) because of other health insurance, I may in the future be able to enroll myself, my spouse, or my dependent child (ren) in this plan, provided that I request enrollment within 30 days after my other health coverage ends. In addition, if I gain a dependent spouse or child (ren) as a result of marriage, birth, adoption, or placement for adoption, I understand I may be able to enroll myself, my spouse and my dependent child (ren), provided that I request enrollment 30 days after the marriage, birth, adoption or placement for adoption.

Signature of Employee: _____ Date Signed : _____

Signature of Spouse : _____ Date Signed: _____

EMPLOYER MUST COMPLETE THIS SECTION

Company Name _____ Group # _____ Date of Hire _____ Effective Date _____ Authorized Signature **(REQUIRED)** _____	Reason for Enrollment (Check One) ☐ Open Enrollment (if applicable) ☐ New Hire ☐ Qualifying Event _____ _____