TOWN OF CLINTON

HEALTH INSURANCE WAIVER

Name:_____

Department _____

I waive my employer's group medical insurance coverage for myself and my eligible dependents *(if applicable).*

REASON FOR WAIVER OF COVERAGE *(please check all that apply)*:

_____I am covered as a spouse or dependent under another group medical plan.

_____I am covered by Medicare, non-group, Veterans program or a secondary employer.

Employer:_____

Insurance Company:_____

_____I am not covered by another medical insurance and choose not to participate in the Town of Clinton's health insurance plan at this time.

_____Other (requires explanation):_____

_____

ACKNOWLEDGEMENT

I waive my eligibility to enroll in the Town of Clinton Health Insurance Plan at this time. I understand that I may enroll under this plan in the future under the terms defined in the eligibility section of the subscriber certification or benefits description.

Employee Signature:_____Date:_____