WAIVER OF COVERAGE

Individuals who are waiving coverage (for themselves or their eligible dependents) during their open enrollment period must complete and sign this section of the health questionnaire. The reason for not requesting coverage through Welborn Health Plans must be clearly stated on this form. If you are electing to waive medical coverage, please read and signify your understanding by signing the following:

I, ____ (Print Name), understand and acknowledge that I am waiving coverage under Welborn Health Plans, and the failure to elect coverage during this initial enrollment period permits the plan to impose, should I later decide to elect coverage, restrictions that apply to "late enrollees":

I refuse the following health care coverage:

- ☐ Employee, spouse and child(ren) coverage
- ☐ Spouse coverage
- ☐ Child(ren) coverage

Reason for Refusal:
(Please check all appropriate boxes.)

- ☐ other group coverage sponsored by my employer
- ☐ other group coverage sponsored by my spouse's employer
- ☐ other reasons (please explain) __________________________________

"Late Enrollee" means an eligible employee or a dependent of an eligible employee who has declined health coverage under a health benefit plan offered through employment or sponsored by an employer at the time of the initial enrollment period provided under the terms of the health benefit plan, and who subsequently required enrollment in a health benefit plan of that employer, provided that the initial enrollment period shall be a period of at least 30 days. Individuals who meet the following criteria will **not** be considered “late enrollees”.

1. Individuals who stated at the time of initial enrollment that coverage under another health insurance plan was the reason for declining enrollment; and they are now applying for coverage with Welborn Health Plans because coverage under the previous plan has terminated due to death or divorce of a spouse, termination of the other plan by an employer or the insurance carrier, termination of employment, reduction in the number of hours of employment, or termination of employer contributions towards the coverage; and such individuals are applying no later than thirty (30) days after the date of exhaustion of coverage.

2. Individuals whose employer offers multiple health insurance plans, and this individual is applying during Welborn Health Plans Open Enrollment period;

3. The individual is applying for dependent coverage in order to comply with a court order and makes application no later than thirty (30) days after the issuance of the court order; or

4. The individual stated at the time of initial enrollment that coverage under another health insurance plan was the reason for declining enrollment, whose coverage was under a COBRA continuation provision, the provision was exhausted and they are applying no later than thirty (30) days after the date of exhaustion of coverage.

I certify that Welborn Health Plans group medical coverage has been offered to me and my dependents and that my decision to refuse medical coverage is not due to any suggestion or pressure by my employer, the insurance agent or broker, any representative of Welborn Health Plans.

Signature of Employee: ____ Date: ____________________