

# WAIVER FORM

## MERCYCARE HEALTH PLANS MERCYCARE INSURANCE COMPANY - MERCYCARE HMO, INC. PO BOX 2770, JANESVILLE, WI 53547-2770 608-752-3431 FAX: 608-752-3751

### 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 \_\_\_\_\_ Work Telephone \_\_\_\_\_  
Employer's Name \_\_\_\_\_ Date of Hire (Month/Date/Year) \_\_\_\_\_

### 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. I am **not** enrolled for coverage under the Health Insurance Risk-Sharing Plan (HIRSP). If currently covered, please attach a copy of your identification card for that plan.
- I, the employee, do not have a risk characteristic or other attribute that would be the sole cause for the small employer insurer to make a decision with respect to premiums or eligibility for a policy that is adverse to the small employer.
- My spouse is covered or will be covered under another plan that is not sponsored by this employer. My spouse is **not** enrolled for coverage under the Health Insurance Risk-Sharing Plan (HIRSP). 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. My dependent child (ren) is **not** enrolled for coverage under the Health Insurance Risk-Sharing Plan (HIRSP). 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.
- I am **not** enrolled under the Health Insurance Risk-Sharing Plan (HIRSP) and the annualized premium contribution to be paid by me on behalf of my dependent spouse and child (ren) would exceed **10%** of my **annualized gross earnings from this employer**.
- 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: \_\_\_\_\_

### FOR EMPLOYER ONLY

Company Name \_\_\_\_\_ Group # \_\_\_\_\_  
Date of Hire \_\_\_\_\_ Effective Date \_\_\_\_\_  
Approved by (signature) \_\_\_\_\_

Reason for Enrollment (Check One)  
 Open Enrollment  
 New Hire  
 Qualifying Event