



EMPLOYEE INFORMATION (Please print) _____

Employee Name: _____

Employer: _____

WAIVER INFORMATION _____

I understand that I am eligible to participate in the group health plan offered through my employer and have been given the opportunity to do so. **I DO NOT** want coverage. I am declining coverage at this time due to the following:

- I currently have coverage elsewhere
- Covered by Medicare
- Individual policy
- Covered by Medicaid
- Group continuation coverage (COBRA)
- Other

CURRENT HEALTH INSURANCE INFORMATION (This section must be completed) _____

Policy Holder's Name: _____

Relationship to Policy Holder: _____

Insurance Carrier: _____

Policy Number: _____ Effective Date: _____

Policy type: Individual Group Employer Name: _____

SIGNATURE (This form must be signed)

I understand that if I and/or my dependent(s), if any, waive coverage, I may not again be eligible for coverage until the next open enrollment period, which is established by my employer and Altius. If I am declining enrollment for myself or my dependents (including my spouse) because of other health insurance or group health plan coverage, I may be able to enroll myself and my dependents in this plan if I or my dependents lose eligibility for that other coverage (or if the employer stops contributing towards my or my dependents' other coverage). However, I must request enrollment within 30 days after my or my dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents. However, I must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. Requests for special enrollment or more information may be directed to Altius Health Plans, Customer Service Department, 801-323-6200 or 800-377-4161.

Employee Signature: _____ Date Signed: _____