Waiver of Group Health Plan Coverage

If you wish to waive coverage this form must be filled out for underwriting purposes.

Company Name **Lamers Bus Lines, Inc.**	Jobsite Location	Date of Hire
Employee Name (Last, First, M.I.)	Social Security Number	Date of Birth
Home address		
City	State	Zip code

For the plan year effective ____/____/_____ I am waiving coverage [due to:]

☐ My preference not to have coverage

☐ Coverage under my parent's plan or spouse/domestic partner's plan
Name of carrier:_____ Policy ID: _____

☐ Other coverage – name of carrier: _____
The other coverage is: ☐ Individual ☐ COBRA ☐ Medicare ☐ Tricare
☐ Medicaid ☐ Employer – Sponsored Group Plan

Proof of other coverage - ***Please make a copy of the front and back of your current insurance identification card and attach the copy to this form for verification purposes. Your name must be visible on the card; otherwise a letter from the insurance provider is required confirming you are a covered individual.*** **Proof of coverage is required.**

Please review, initial and sign below, where applicable, if you wish to waive coverage.

By signing below, I certify that I have been given an opportunity to apply for coverage for myself and my eligible dependent(s) (if any), through my employer. I understand that I am declining enrollment for myself or my eligible dependent(s) (if any) as indicated above. I also understand that I may be able to enroll myself and my eligible dependent(s) (if any) in this plan if I lose, or my eligible dependent(s) lose, eligibility for other coverage that is currently in effect. *Initial:* _____

I understand that I must request enrollment no more than 30 days after the date the other health plan coverage ends. If I do not do so, I will not be able to enroll until my employer's next annual open enrollment period. *Initial:* _____

In addition, I understand that if I have a newly eligible dependent as a result of a marriage, birth, adoption, or placement for adoption (a Qualified Life Event or QLE), I may be able to enroll myself and my eligible dependent(s). However, I must request enrollment within 30 days from the aforementioned QLE. *Initial:* _____

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Signature of Employee **Date of Signature**

Mail form to: The Boon Group, P.O. Box 9788 Austin, TX 78766
Fax form to: (512) 339-6662 Attn: Enrollment
Email: enrollment@theboongroup.com