Arizona Employee Waiver Form

You, the employee, must complete this waiver (if eligible but declining or waiving coverage). You are solely responsible for its accuracy and completeness. To avoid the possibility of delay, answer all questions and be sure to sign and date your waiver. Please complete this form in blue or black ink, and submit this to your employer when complete.

Section A: Information to be completed by the employer

Employer name	Employer group number (if available)

Section B: Employee information

Employee first name	M.I.	Last name	
Social Security Number	Gender Male Female		Date of birth (mm/dd/yyyy)
Phone number		Email address	

Section D: Waiver / declining coverage

Reason(s) for declining coverage (please check all that apply):

- Covered by another group's health plan
- Covered by Medicare or TRICARE® coverage
- Enrolled as an individual in another health plan
- Enrolled as a dependent in health plan through a different employer
- Religious Beliefs
- I elect not to have coverage
- Other reasons (please explain):

Carrier

Policy number

If you chose Medicare or TRICARE for declining coverage, please specify one below:

Medicare TRICARE

Policy number

Section E: General agreement

Please read this section carefully, and please sign only if declining coverage:

I acknowledge that the available coverage has been explained to me by my employer and I know that I have every right to apply for coverage. I have been given the chance to apply for this coverage and I have decided not to enroll myself and/or my dependent(s), if any. I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to waive coverage. By waiving group medical coverage (unless employee and/or dependents have group medical coverage elsewhere) I acknowledge that my dependents and I may have to wait until the next open enrollment to be enrolled in this group's medical plan unless I qualify for special open enrollment.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). Please see your Evidence of Coverage or Underwriting Guidelines for more information, including the special enrollment periods. To request special enrollment, please reach out to your employer's Human Resources or Benefits contact.

Applicant signature Sign here	Printed name	Date (mm/dd/yyyy)

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