



Waiver of Group Health Benefits & Notice of Special Enrollment Rights

Plan Year Dates: 07/01/2025 – 06/30/2026

Employee Name: _____
(Last Name) (First Name) (MI)

I am waiving coverage for:

- Myself
- Spouse/Domestic Partner
- Dependent(s)

I am waiving coverage due to:

- My preference not to have coverage
- Coverage under my spouse's/domestic partner's plan
- Other coverage

This other coverage is: Individual COBRA Medicare Medicaid
 MNsure Employer-Sponsored Group Plan

Special Enrollment Notice – *Please review and sign below if you wish to waive coverage.*

By signing below, I certify that I have been given the opportunity to enroll in health coverage for myself and my eligible dependents, if any. I am declining enrollment as indicated above. I understand that I am declining enrollment for myself or my eligible dependents (including my spouse) because of other health insurance or group health plan coverage. I may be able to enroll myself and my eligible dependents in this plan if I lose, or my eligible dependents lose, eligibility for that other coverage (or if the employer stops contributing towards my or my eligible dependents' other coverage).

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.

In addition, I understand that if I have a newly eligible dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my eligible dependent(s). However, I must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

I understand that in order to request special enrollment or obtain more information, I should contact Katie Pekarna-Damlo.

Signature of Employee

Date