



Asuris Northwest Health
 1800 Ninth Avenue
 PO Box 91130
 Seattle, Washington 98111

Waiver Form

SECTION 1 - GROUP INFORMATION

Group Name	Group Number								
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SECTION 2 - EMPLOYEE INFORMATION

Employee Name (Last, First, Middle)		
Employee Date of Hire	Employee average number of hours worked per week	Waiving coverage for: <input type="checkbox"/> Employee <input type="checkbox"/> Employee/Dependents <input type="checkbox"/> Dependents Only

SECTION 3 - WAIVING COVERAGE INFORMATION

I have been offered coverage under my group's plan through Asuris Northwest Health, but I am waiving coverage for the following reason(s).

Check all that apply:

- I do not wish to enroll myself and/or my dependents in my group's medical plan at this time
- I currently have medical coverage elsewhere:

Carrier _____

Policy Number _____

Policy Type: Group Medicare TriCare Other _____

- I do not wish to enroll myself and/or my dependents in my group's dental plan at this time
- I currently have dental coverage elsewhere:

Carrier _____

Policy Number _____

If you are waiving coverage under this medical/dental plan 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 under this plan if you or your dependents lose eligibility for that other coverage (or an employer stops contributing towards that other coverage), provided that you request enrollment within 30 days after your or your dependents' other coverage ends (or employer contributions stop). In addition, if you waive enrollment under this medical/dental plan at this time, and later acquire a new dependent due to marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents under this plan, provided that you request enrollment within 30 days after the marriage, or within 60 days after the birth, adoption, or placement for adoption. Please contact your Group Administrator if you require further information.

I understand that I and/or any of my dependents will be unable to obtain coverage under my group's plan through Asuris Northwest Health until the next annual enrollment period, unless I and/or my dependents qualify for a special enrollment period.

I have provided these answers as part of the application procedure required by Asuris Northwest Health to waive coverage and I certify that all information completed on this form is true, correct, and complete. I understand that Asuris Northwest Health will rely on each answer in making coverage and rating determinations. For protection of all members, fraud or misrepresentation of material fact by me for the purposes of defrauding Asuris Northwest Health may result in Asuris Northwest Health taking any action allowed by law or contract, including termination or rescission of coverage, denial of benefits, and/or pursuit of criminal charges and penalties.

I hereby verify that I have reviewed all the information provided on this application (regardless of whether I completed it or someone else assisted me with completion) and certify that it is accurate and complete. I agree to promptly inform Asuris Northwest Health in writing if anything happens before my coverage takes effect that makes any answer on this application inaccurate or incomplete.

Signature of Employee
Date

