Waiver of Coverage

Employer Name
Applicant Date of Hire: ______ / ______ / ______

Waiver Information (Complete All Sections - Please Print)

Last Name	First Name	M.I.	Sex	Date of Birth	Social Security Number

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Enrollee Prior Coverage? ☐ Yes ☐ No If yes, how many?

Family Members (To be waived)

Relationship to Employee	Last Name	First Name M.I.	Sex	Date of Birth	Currently Covered Yes / No	If yes, Name of Carrier

Confirmation of Decision to Decline Coverage

This is to confirm that I decline to participate in the Washington Farm Bureau heath care program(s) offered through my employer's group health plan as follows (Please mark all that apply):

☐ I do not wish to enroll **myself**. I have other health care coverage.

☐ I do not wish to enroll **myself**. I do not have other health care coverage.

☐ I do not wish to enroll my ____ **spouse** ____ **child(ren)**. They have other health care coverage.

☐ I do not wish to enroll my ____ **spouse** ____ **child(ren)**. They do not have other health care coverage.

I understand that by **declining** enrollment for myself or dependents (including my spouse) because of other health care coverage, I may in the future enroll my dependents or myself in this plan only under the conditions stated herein. To be eligible at another time, I must have **involuntarily** lost my other coverage and we must receive your enrollment application within 30 days after your other coverage ended.

Additionally, 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 dependents, provided we receive your completed enrollment application within 60 days after the marriage, birth, adoption, or placement for adoption. I understand that these are the only conditions under which I may enroll after my current initial eligibility.

Applicant / HIPAA Acknowledgement. I am an active full-time employee regularly working at least 30 hours per week. All information given by me on this form is true and complete. My signature below certifies the carrier/coverage data provided above is complete and accurate to the best of my knowledge, and can be documented upon request with Group Health Plan Coverage Certificates from my, and my dependents prior plan(s). I acknowledge the authorization for the Washington Farm Bureau to obtain information from third parties regarding any matters that may bear on this application.

I have provided these answers as part of the application procedure required by the issuer to waive coverage and I certify that all information completed on this form is true, correct, and complete. I understand that the issuer 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 the issuer may result in the issuer 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.

Original Applicant Signature:

Date: