Diocese of Worcester
Group Medical Insurance
Waiver Form

Location Name:

Employee's Name:

Date of Birth:

_____

Medical

☐ I waive my employer's group Medical insurance coverage for myself and my eligible dependents (if any).

Reason for Waiver of Coverage - check all that apply:

☐ I am covered as a spouse or dependent under another group Medical plan.

☐ I am covered by Medicare, non-group, Veterans program or a secondary employer.

Employer Name: _____

Insurance Company: _____

☐ I am not covered by another Medical insurance and choose not to participate in my employer's group plan at this time.

Other (requires explanation):_____

I waive my and/or my dependents' (if any) eligibility to enroll in my employer's group plan at this time. I understand that I and/or my dependents may enroll under this plan in the future under the terms defined in the eligibility section of the insurance carriers subscriber certificate or benefit description.

Employee Signature: _____ Date: _____