Employee waiver form

Reform groups (2-50 eligible employees)

This form is required for all eligible employees who are not enrolling with Priority Health at the time of initial enrollment and/or the group's open enrollment period.

I understand that I am eligible for Priority Health coverage through my employer and that my employer is required to contribute at least 75% of the single rate **or** no less than 50% of the single, double, and family rate.

I waive the right to enroll with Priority Health as offered to me by my employer for the following reason (please check one):

- ☐ I have other coverage offered by my employer.
- ☐ I have other coverage through my spouse or other family member.
- ☐ I have other coverage through Medicare or as a retiree from another employer.
- ☐ I have individual coverage through another source that is not employer-sponsored or employer-paid.
- ☐ I have no other coverage but choose not to enroll in my employer's plan.

I understand that I will not be eligible for coverage through Priority Health until my employer's next open enrollment period unless I qualify for coverage due to a HIPAA qualifying event (such as marriage, birth of a child, adoption, or loss or other coverage).

Employee name printed

Employee signature Date

Employer signature Date

Group name Priority Health group number