

# Waiver of Coverage

**AvMED**  
**HEALTH PLANS**

9400 South Dadeland Blvd.  
Miami, FL 33156  
800-432-6676

Employee Name \_\_\_\_\_ Social Security Number \_\_\_\_\_  
(Please print)

Company Name \_\_\_\_\_

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 31 days after your other coverage ends.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

This is to acknowledge that my employer explained the benefit plans available to me. I was given the opportunity to apply for the available benefit plans and have elected not to enroll.

Reason for declining coverage:

I am covered through my spouse's employer\*.

Name of spouse's employer \_\_\_\_\_

Name of insurance company \_\_\_\_\_

Type of Insurance:  Single  Family Group # \_\_\_\_\_

I am covered through the Federal Government\*.

CHAMPUS or CHAMPVA  Medicare  Medicaid

Does the above cover all family members?  Yes  No

I am covered through an individual policy\*.

Name of insurance company \_\_\_\_\_

Type of insurance:  Single  Family

Effective Date \_\_\_\_\_ Policy # \_\_\_\_\_

I have no insurance.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

\* Please include a copy of your insurance card.