Monadnock Developmental Services' Waiver of Group Health/Dental Benefits and Notice of Special Enrollment Rights

Please read and complete the following:

Employee Name: ____

For the plan year effective _______/_______/______ I am waiving coverage for:

◯ Myself

◯ Spouse

◯ Dependents – Please list names: ____

I am waiving: ◯ Health and/or ◯ Dental (check one or both) coverage due to:

◯ Coverage under my spouse's/domestic partner's plan – name of carrier: ______________________

◯ Other coverage – name of carrier: ________________________________

The other coverage is ◯ Individual ◯ COBRA ◯ Medicare ◯ Medicaid

◯ Employer Sponsored Group Plan ◯ TRICARE (formerly CHAMPUS)

Special Enrollment Notice and Certification – Please review and sign below if you wish to waive coverage.

By signing below, I certify that I have been given an opportunity to apply for coverage for myself and my eligible dependents, if any. I am declining enrollment as indicated above. I understand that I am declining enrollment for myself or my eligible dependents (including my spouse) because of other health insurance or group health plan coverage, I may be able to enroll myself and my eligible dependent in this plan if I lose, or my eligible dependents lose, eligibility for that other coverage (or if the employer stops contributing towards mine or my eligible dependents' other coverage).

I understand that I must request enrollment no more than 30 days after the date the other health plan coverage ends (or after the employer stops contributing toward the other coverage). If I do not do so, I will not be able to enroll until my employer's next annual open enrollment period.

In addition, I understand that if I have a newly eligible dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my eligible dependent(s). However, I must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

I understand that in order to request special enrollment or obtain more information, I should contact my group administrator.

Signature of Employee: _________________________________ Date: ____________________