

# ROSE STATE COLLEGE

## Waiver of Health Insurance

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I acknowledge that I have been offered the opportunity for health coverage from the Employees Group Insurance Division (EGID) for myself and my dependents through my employer.

I decline enrollment at this time because:

I have other Medical coverage provided by:

**Please provide proof of insurance – copy of your insurance card is acceptable.**

*Insurance company name* \_\_\_\_\_

*Policy No.* \_\_\_\_\_

*Employer* \_\_\_\_\_

I do not wish to enroll myself in any type of medical coverage at this time.

I do not wish to enroll my  spouse  child(ren) in any type of medical coverage at this time.

If you are declining enrollment for yourself or dependents (including your spouse) because of other health care coverage, you may enroll yourself or your dependents in this plan prior to the next enrollment period (under certain circumstances). To do this, you must have involuntarily lost your other coverage and we must receive your enrollment application within 30 days after your other coverage ended. Additionally, if you have new dependents as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and dependents, provided we receive your completed enrollment application within 30 days after the marriage, birth, adoption, or placement for adoption.

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_