



Group Insurance Waiver Form

Please mail completed form to:
P.O. Box 19040
Kalamazoo, MI 49019-0040

Phone: (269) 343-2611
(616) 940-2099

www.groupmarketingservices.com

WAIVER OF GROUP INSURANCE PLAN (TIMELY ENROLLMENT)

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EMPLOYEE'S NAME <small>(First, Middle, Last)</small>	Please Print	DATE EMPLOYED
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EMPLOYER NAME: _____

I / My Dependent(s) *have other group health plan coverage* or other health insurance coverage. I / My Dependent(s) understand I / My Dependent(s) will only be given an opportunity again for Timely Enrollment if I apply properly within 31 days of losing my other group health plan coverage or other health insurance coverage or if I apply within 31 days of acquiring a new dependent either by marriage, birth or adoption as described below in "Special Enrollment".

DESCRIBE OTHER COVERAGE:

Other coverage through Spouse's Plan with _____
(Name of Insurer and/or Employer)

Other coverage through _____
(Name of Insurer, Policy No. and/or Plan)

I / My Dependent(s) *have no other coverage*. I / My Dependent(s) understand I / My Dependent(s) will only be given an opportunity again for Timely Enrollment if I apply properly within 31 days of acquiring new dependent(s) either by marriage, birth or adoption as described below in "Special Enrollment".

MARK ALL COVERAGE(S) YOU ARE WAIVING:

- | | | |
|---|--|--|
| <input type="checkbox"/> Employee Health | <input type="checkbox"/> Dependent Spouse Health | <input type="checkbox"/> Dependent Child(ren) Health |
| <input type="checkbox"/> Employee Dental/Optical | <input type="checkbox"/> Dependent Spouse Dental/Optical | <input type="checkbox"/> Dependent Child(ren) Dental/Optical |
| <input type="checkbox"/> Employee Life/Disability | <input type="checkbox"/> Dependent Spouse Life | <input type="checkbox"/> Dependent Child(ren) Life |

Other: _____

"Timely Entrant" and "Timely Enrollment" means an Employee or Dependent who applies for insurance within 31 days of first becoming eligible. A person who enrolls during a Special Enrollment Period is a Timely Entrant.

SPECIAL ENROLLMENT

If you decline enrollment for yourself or your dependent(s) because of other health insurance coverage, you may in the future enroll yourself and/or your dependent(s) in this plan, if:

- The other coverage is terminated as a result of involuntary Loss of Eligibility, provided you request enrollment in writing by completing form GP2917 and the original form is received at Group Marketing Services, Inc. within 31 days after your other coverage ends. "Loss of eligibility" includes loss of coverage due to legal separation, death, divorce, termination of employment or reduction in hours. It does not include a loss of coverage due to failure to pay premiums or termination for cause such as making a fraudulent claim. If completed proper original enrollment is received within 31 days of losing other creditable health plan coverage then this group medical insurance coverage with the employer named will be effective the first of the calendar month following receipt of original completed enrollment by Group Marketing Services, Inc. **Facsimiles are not considered original completed enrollment.**
- You have a new dependent as a result of marriage, birth, adoption or placement for adoption, provided you request enrollment in writing on form GP2917 and the original completed enrollment is received by Group Marketing Services within 31 days after the marriage, birth, adoption or placement for adoption. The coverage will begin on the date of marriage, birth or placement for adoption. **Facsimiles are not considered original or properly completed, acceptable enrollment.**

If you decline coverage because you have COBRA continuation coverage under another plan, you must exhaust your COBRA coverage before you may enroll in this plan.

I hereby certify that the benefits provided under the group insurance made available to me by my Employer have been explained to me and I have been given an opportunity to apply within 31 days of my eligibility period. I have elected to waive that opportunity. I voluntarily decline to participate in the group insurance Plan(s) selected above that I am otherwise eligible to participate in.

Waivers are effective the first of the month following receipt of original by Group Marketing Services, if you are already insured.

Employee Signature	Date	Member ID or Social Security
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