Group Marketing Services, Inc.
Group Insurance That Benefits Small Business

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

Phone: (269) 343-2611
(616) 940-2099
www.groupmarketingservices.com

GROUP INSURANCE WAIVER FORM

EMPLOYEE'S NAME: (First, Middle, Last) Please Print _____ DATE EMPLOYED _____

EMPLOYER NAME: _____

MARK ALL COVERAGE(S) YOU ARE WAIVING:

Employee Coverage	Spouse Coverage
Health: ☐ Waive / Decline	Health: ☐ Waive / Decline
Dental/Vision: If offered, same election as Health, benefits packaged	Dental/Vision: If offered, same election as Health, benefits packaged
Life: No waivers, mandatory coverage	Life: Mandatory coverage (no waivers allowed)
Disability: If offered, no waivers, mandatory coverage	Disability: Not Available

Child(ren) Coverage
Health: ☐ Waive All Child(ren) or ☐ Waive Only Certain Child(ren): _____
Dental/Vision: If offered, same election as Health, benefits are packaged
Life: No waivers, mandatory coverage

Other than through the above employer, are you, your spouse or your child(ren) covered by any other insurance plan (including MEDICARE)? ☐ No ☐ Yes. IF YES, DESCRIBE OTHER COVERAGE:

WHO IS COVERED: _____

Policyholder Name & D.O.B.	Relationship	Name of Carrier	Effective Date	Type of Policy (Group, COBRA or Individual)

Future Enrollment Opportunities: If you are declining/waiving any coverage you or your dependents are eligible for during your initial enrollment period, PLEASE NOTE: there are only certain times this plan allows you and/or your depdent(s) an opportunity to once again enroll. The following are those enrollment times:

- Open Enrollment (annually): a one (1) month enrollment period, beginning four (4) months prior to your group's renewal date. To enroll during Open Enrollment *the applicant(s) may not have any other health insurance coverage* and you must have submitted a proper written waiver when you were first eligible to enroll (i.e. Initial Enrollment). Form GP2917 must be completed and the original must be received by Group Marketing Services during the month of Open Enrollment. Coverage will begin on the first of the calendar month following thirty (30) days after the receipt of original completed enrollment by Group Marketing Services, Inc. Facsimiles are not considered original completed enrollment.
- Special Enrollment (enrollment triggered by an event):
  - New Dependent: : If you acquire a new dependent as a result of marriage, birth, adoption or placement for adoption you may enroll yourself and/or your new dependent(s) in this plan. Form GP2917 must be completed and the original must be received by Group Marketing Services within 31 days after the event. Coverage will begin on the date of the event. Facsimiles are not considered original or properly completed, acceptable enrollment.
  - Involuntary Loss of Coverage: If you originally decline/waive coverage because you or your dependents have other health coverage, you may enroll if the other coverage is terminated as a result of involuntary loss of eligibility. Some examples of an involuntary loss of eligibility are a 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, waiver of coverage or termination for cause such as making a fraudulent claim. 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. To enroll, form GP2917 must be completed and the original must be received by Group Marketing Services within 31 days of the loss of coverage date. Coverage will begin on the first of the calendar month following receipt of original completed enrollment by Group Marketing Services, Inc. Facsimiles are not considered original completed enrollment.

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