WAIVER OF ALL MEDICAL COVERAGES

MEDICAL – DENTAL - VISION

The purpose of this Waiver of Group Coverage Form is to decline coverage for yourself and/or dependents effective the first day of the month immediately following the date the signed form is submitted to the Plan Administrator. The submitted form will establish your right to apply for coverage within 30 days after the termination or loss of other group health coverage.

Proof of other group coverage must accompany this form when submitted to the Administrator.

Section A	**EMPLOYER NAME AND TRUST FUND NAME**
Employer Name	Trust Fund Name

WAIVER FOR: SELF AND DEPENDENT(S) ❒ DEPENDENT(S) ❒

Section B	**EMPLOYEE INFORMATION**				
Last Name	First Name	Middle Int.	Birth Date	LAST 4 DIGITS OF SSN	Sex M F
Address		Home Phone		Business Phone	
City		State		Zip Code	
Date of Hire : _____/_____/_____		Effective Date of Waiver: _____/_____/_____			

Section C **LIST BELOW SPOUSE OR DOMESTIC PARTNER AND ANY DEPENDENTS**

	Last Name	First Name	Date of Birth	Sex	Other Group Health Carrier Name & Policy #
Spouse					
Dependent					
Dependent					
Dependent					
Dependent					

Section D **HIPAA SPECIAL ENROLLMENT RIGHTS**

The Plan is required to permit individuals, who declined health coverage under the Plan because they have other group health plan or health insurance coverage, to enroll in the plan through special enrollment upon any "loss of eligibility" for the other coverage or if employer contributions toward the other coverage cease.

- Under HIPAA, eligible individuals, who declined group health coverage due to being enrolled in another group health plan, must be permitted to enroll in the plan (regardless of any late enrollment provisions) upon "loss of eligibility" for the other group health coverage or if employer contributions toward the other group health coverage ceased.
- Loss of eligibility includes loss of coverage due to legal separation, divorce, voluntary or involuntary termination of employment, reduction in hours, children's aging out of coverage, or moving out of an HMO service area. It does not include loss of coverage due to a failure of the individual to pay premiums on a timely basis or termination of coverage for cause.

Under HIPAA, special enrollment rights are also triggered when employer contributions toward an individual's other coverage cease, regardless of whether the individual is still eligible for coverage under the other plan.

What do I need to know about special enrollment due to loss of coverage?

To be eligible for special enrollment due to loss of other coverage, **ALL** of the following must be true.

- When you were first offered the opportunity to enroll, you declined to enroll yourself and/or your dependents because you and/or your dependents were enrolled in other group health coverage.
- At the time you declined to enroll, you submitted to the Plan Administrator a completed and signed Waiver of Coverage form.
- Within 30-days of the loss of other group coverage, you submitted to Plan Administrator a HIPAA certificate confirming the loss of the other group coverage.
- If the other coverage was COBRA coverage or Temporary Continuation of Coverage (TCC), the coverage has been exhausted
- You did not lose your other coverage because you didn't pay your premiums or because you committed fraud

What events trigger a special enrollment period?
Special enrollment is required in two situations.

a) You or your dependent lose other group health coverage; and
b) You have a new eligible dependent through marriage, birth, adoption, or placement for adoption with you.

You or your dependent lose other health coverage

- To get a special enrollment opportunity in this situation, the employee and/or dependent must earlier have declined to enroll in the group health plan because he or she had other coverage.
- If the other coverage was COBRA continuation coverage, special enrollment can be requested only after the COBRA coverage is exhausted.
- If the other coverage was NOT COBRA continuation coverage, the individual can request special enrollment when his/her other group coverage ends because the individual is no longer eligible.
- A special enrollment period must be given if the employer sponsoring the group health plan stops paying its share of the premiums.
- You have a new dependent through marriage, birth, adoption, or placement for adoption with you.

The child is entitled to special enrollment, if the triggering event is a birth or adoption.

When do I request special enrollment?
If a special enrollment period is triggered when an employee or his/her dependent loses other health coverage, the employee must request the special enrollment(s) within 30 days of the loss of coverage. If a special enrollment period is triggered when a new dependent is added, the individual must request the special enrollment(s) within 30 days of the triggering event.

If you should lose other coverage due to circumstances <u>not</u> covered by the HIPAA Special Enrollment rule, enrollment may be delayed until the Plan's next annual open enrollment period and only if at that time will you be eligible under the Plan Rules and Regulations.

Section E PLEASE READ CAREFULLY AND SIGN BELOW

If after filing this waiver with the Fund one of the following conditions occurs, you and/or your eligible dependents may be eligible to enroll for benefits with the Fund when:

1. Your coverage under another group health plan is lost through termination of employment, change in employment status, termination of employer coverage, termination of other employer's contributions toward that coverage, death or divorce. You will be required to provide the Fund with a copy of your prior group coverage HIPAA Certificate within 30 days of the termination or loss of other group coverage
2. There is a change in family status: (i) marriage (ii) birth or adoption during the coverage period. Spouses, newborns and adopted dependents are not able to enroll unless the member enrolls. You will be required to provide marriage, birth or adoption certificate within 30 days of the event.

I certify that I am not subject to any court order or decrees (QMCSOS, etc.) which restrict my right to decline health coverage for my dependents.

I confirm that I have read and understand HIPAA Special Enrollment Rights which are printed on this form.

I understand that by declining coverage at this time, I waive my right to currently enroll in this plan.

I acknowledge that I understand health care benefits are available to me and my dependents under this Plan. I am releasing and giving up any entitlement to these health care benefits. I understand that my failure to elect coverage at this time may exclude myself and/or my dependents from coverage until the next Annual Open Enrollment.

I certify that the information I have provided herein on the Form is true and correct.

_____ _____
Employee Signature Date

_____ _____
Witness Signature Date