GRAVIE

# Employee Waiver Form

Employer Name: _____

Printed Name (first & last): _____

Date of Birth: _____

Last 4 Digits of SSN: _____

- ☐ I decline coverage for myself
- ☐ I decline coverage for myself and my dependents

Reason for declining coverage:

- ☐ Other group coverage (spouse's/domestic partner's/parent's plan)
- ☐ Medicare
- ☐ Medical Assistance, TRICARE
- ☐ No other coverage
- ☐ Other *(Please explain):* _____

_____

I acknowledge I have been given the opportunity to enroll in group medical coverage provided by my employer. However, I am electing not to enroll. By declining this group health coverage I acknowledge that I and my dependents (if any) may have to wait until the plan's next open enrollment period to enroll for group health coverage.

_____

Employee Signature

_____

Date

SUBMIT COMPLETED FORM TO GRAVIE
40 S. 7TH ST • SUITE 212-302 • MINNEAPOLIS, MN 55402
SECURE FAX: 844-462-0474