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# Employee Waiver Form

This form can also be found online at gravie.formstack.com/forms/employee_waiver

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:**
10 NE 2nd Street Ste 300 Minneapolis, MN 55413 Secure Fax: 844.462.0474 Email: accountservices@gravie.com