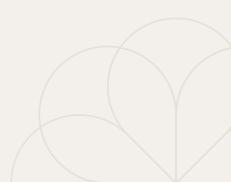




Employee Waiver Form

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