CHEIBA Trust

Waiver of Insurance

A. EMPLOYEE INFORMATION

Employee Last Name	Employee First Name	MI	Social Security Number
			☐☐☐-☐☐-☐☐☐☐

Medical Group Number	Name of Institution

B. WHO IS WAIVING INSURANCE: (Check all that apply)

☐ EMPLOYEE ☐ SPOUSE ☐ DOMESTIC PARTNER ☐ CIVIL UNION PARTNER ☐ CHILD(REN)

C. I/WE DO NOT WISH TO PARTICIPATE IN THE GROUP INSURANCE PLAN, AT THIS TIME, FOR THE FOLLOWING REASON(S):

☐ I have other group health insurance	☐ I choose to have no coverage do to my religious affiliation
☐ I have other coverage through the U.S. Military Services	

D. LIST ALL DEPENDENTS NOT PARTICIPATING IN GROUP COVERAGE INCLUDING SPOUSE

DEPENDENT NAME (First, Middle Initial, Last)	BIRTHDATE (MM/DD/YYYY)	RELATIONSHIP

I hereby certify that I have been given the opportunity to participate in my Employer's Group Insurance Plan. The plan has been explained to me and I decline to participate.

If I am declining enrollment for myself and/or my dependents (including my spouse, Domestic Partner, and Civil Union Partner) because of other group or individual health insurance coverage, I may in the future be able to enroll myself and/or my dependents in this plan, provided that I request enrollment within 31 days after a qualifying event. In addition, if I have a new dependent as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependents, provided that I request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages.

EMPLOYEE SIGNATURE	DATE

COLORADO HIGHER EDUCATION INSURANCE BENEFIT ALLIANCE WAIVER OF INSURANCE

WHITE / Anthem – CANARY / Group Administrator – PINK / Member