DeanHealthPlan
A member of SSM Health

WAIVER OF COVERAGE

Dean Health Plan, Inc. | Dean Health Insurance, Inc.

P.O. Box 56099 Madison, WI 53705 | (800) 279-1301

Please complete in ink.

FOR DHP/DHI USE ONLY:			
Group Number	Accept / Reject	PB	Reason Code

A

Employee Name (Last, First Middle)	Date of Hire	Hrs worked per week	Employer Name
Mailing Address, City, State, ZIP	County	Social Security Number	
Home Phone Number Work Phone Number	**Marital Status** ☐ Single ☐ Married ☐ Divorced ☐ Widowed / Date of Occurrence: _____		Date of Birth

B

I am declining group health insurance coverage for : ☐ Myself ☐ Myself and all eligible dependents ☐ My eligible dependents listed below

***Please complete the following for all dependents waiving coverage*:**

Last Name, First Name & Middle	Relationship to Employee	Social Security Number	Date of Birth	Sex

C

Please check the reasons why you and/or your dependents are waiving coverage.

☐ Persons listed above have other group or individual health insurance. **Please complete the section below*.**

☐ I am, and my dependents are, in good health.

☐ My earnings are such that I would have to pay more than 10% of my annualized gross earnings toward health insurance.

*Please complete this section if you or your dependents have other insurance coverage:

Name of Carrier	Phone Number of Carrier	Policy Number	Name of Policyholder

D

I certify that the above information is complete and true to the best of my knowledge. I certify that I have been given the opportunity to apply for group health insurance coverage and I decline to enroll as indicated above, on behalf of myself and/or my eligible dependents. I have read and understand the provisions stated below regarding special enrollment rights. I also understand that if I apply for coverage in the future, I and/or my eligible dependents will be considered a Late Enrollee(s) and will be subject to a pre-existing condition exclusion and/or a waiting period for up to 18 months, provided I and/or my eligible dependents are still eligible for coverage and are not entitled to a special enrollment period as described below. Further, I certify that I and/or my eligible dependents have not been influenced in any way to waive coverage through Dean Health Plan by my employer, agent or Dean Health Plan/Dean Health Insurance.

Employee Signature _____ Date Signed _____ Spouse Signature _____ Date Signed _____

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.