Mass General Brigham
Health Plan

Health Coverage Waiver Form

Employer Group Name: _____

Employee Name: _____

On behalf of myself and my eligible dependents (if any), I waive the option to enroll in Mass General Brigham Health Plan health insurance offered at this time by or through my employer for the following reason:

- ○ I am covered under another plan as a spouse or dependent
- ○ I am covered under another health plan sponsored by my employer
- ○ I am covered under Medicare or Medicaid
- ○ I do not wish to participate in health care benefits at this time
- ○ Other _____

If you are declining to enroll in Mass General Brigham Health Plan at this time because of other health care coverage, please provide the following information.

Insurer Name: _____

Group Policy Number _____

Notice of Enrollment rights:

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this health plan, provided that you request enrollment within 60 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 60 days after the marriage, birth, adoption or placement for adoption.

I understand that any person choosing to enroll later must meet Mass General Brigham Health Plan' requirements for eligibility and for late enrollees.

Employee Signature: _____ Date: _____

Employer Signature: _____ Date: _____