ASURIS NORTHWEST HEALTH

Asuris Northwest Health
528 East Spokane Falls Boulevard
Suite 301
Spokane, WA 99202
Mail form to: PO Box 1106
Lewiston, ID 83501
Fax to: 1-866-303-5117

Waiver Form

SECTION 1 - GROUP INFORMATION

Group's Name	Group Number (for existing groups only)

SECTION 2 - EMPLOYEE INFORMATION

Name (Last, First, Middle)	Date of Birth

Date of Hire	Average number of hours worked per week	Waiving coverage for:
		☐ Employee ☐ Employee/Dependent(s)

SECTION 3 - WAIVING COVERAGE INFORMATION

I have been offered coverage under my group's plan through Asuris Northwest Health (Asuris), but I am waiving coverage for the following reason(s). **Check all that apply:**

Medical

☐ I do not wish to enroll myself and/or my dependent(s) in my group's **medical** plan at this time.

☐ I currently have medical coverage elsewhere:

Carrier_____

Policy Type: ☐ Group ☐ Individual ☐ Medicare ☐ TriCare ☐ Other_____

Dental

☐ I do not wish to enroll myself and/or my dependent(s) in my group's **dental** plan at this time.

☐ I currently have dental coverage elsewhere:

Carrier: _____

Policy Type: ☐ Group ☐ Individual ☐ Medicare ☐ TriCare ☐ Other _____

If you are waiving coverage under this medical/dental plan for yourself and/or your dependent(s) because of other health insurance, you may be able to enroll yourself and your dependent(s) under this plan if you or your dependent(s) lose eligibility for that other coverage or an employer stops contributing towards other group coverage, provided that you request enrollment within 30 days after you or your dependent's other coverage ends or employer contributions stop. In addition, if you waive enrollment under this medical/dental plan at this time, and later acquire a new dependent due to marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependent(s) under this plan, provided that you request enrollment within 30 days after the marriage, or within 60 days after the birth, adoption, or placement for adoption. Please contact your Group Administrator if you require further information.

I understand that I and/or any of my dependent(s) will be unable to obtain coverage under my group's health plan through Asuris until the next annual enrollment period, unless I and/or my dependent(s) qualify for a special enrollment period.

I have provided these answers as part of the application process required by Asuris to waive coverage and I certify that all information completed on this form is true, correct, and complete. I understand that Asuris will rely on each answer in making coverage and rating determinations. It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

I hereby verify that I have reviewed all the information provided on this application (regardless of whether I completed it or someone else assisted me with completion) and certify that it is accurate and complete. I agree to promptly inform Asuris in writing if anything changes before my coverage takes effect that makes any answer on this application inaccurate or incomplete.

▶_____ _____

Signature of Employee Date