



WAIVER / VERIFICATION OF ALTERNATIVE COVERAGE

I, _____, certify that I am an employee
(employee name)
_____ and that I am eligible for health
(Company name)
care coverage with this company. I also certify that I am waiving my right to group health
coverage at this time for the following reason:

I currently have current health care coverage thru:

- My spouse
- Another employer sponsored health plan
- Medicare

- I do not wish to carry health insurance coverage

Name: _____

Employee Signature: _____ Date: _____

Authorized Company Representative Signature: _____