WASHINGTON ALLIANCE FOR HEALTHCARE INSURANCE TRUST
WAIVER OF COVERAGE FORM

This is to confirm that I decline to participate in the programs offered through my employer's group health plan as follows:

❑ I do not wish to enroll **myself.** I have other health care coverage.

❑ I do not wish to enroll **myself.** I do not have other health care coverage.

❑ I do not wish to enroll my ❑ **spouse** ❑ **child(ren).** They have other health care coverage.

❑ I do not wish to enroll my ❑ **spouse** ❑ **child(ren).** They do not have other health care coverage.

If you are declining enrollment for yourself or dependents (including your spouse) because of other health care coverage, you may in the future enroll yourself or your dependents in this plan prior to the next open enrollment period. To do this, you must have involuntarily lost your other coverage and we must receive your enrollment application within 30 days after your other coverage ended. Additionally, 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 dependents, provided we receive your completed enrollment application within 60 days after the marriage, birth, adoption, or placement for adoption. See your medical plan booklet for more details.

Employee Name: ______________________ Employee Signature: ________________________

Employer Name: ____

Date: ____