MEDICAL WAIVER RELEASE & CANCELLATION REQUEST
BIAW / MBA / NMTA / CAMPS / BIIT

FOR EMPLOYEES WHO OPT OUT OF THE EMPLOYER INSURANCE PLAN

SECTION 1 - REASON FOR WAIVER:

☐ **CANCEL EXISTING MEDICAL GROUP COVERAGE DUE TO WAIVER (Complete Section 2)***

Cancellation Date: _____

***Please note submission of this form is to be used for medical coverages only. If you wish to cancel any other type of coverage, please submit the cancellation request on EPKonnect or by submitting a change request form.**

☐ **INITIAL/NEW HIRE WAIVER OF INSURANCE (Complete Waiver information below)**

Hire Date: _____

SECTION 2 - WAIVER / OTHER COVERAGE INFORMATION:

☐ **I am opting out of my Employer's insurance plan because I currently have coverage through:**

☐ Medicare ☐ Military ☐ Tribal ☐ Spouse ☐ Parent ☐ Individual Plan

Insurance Carrier: _____ Group Number: _____

☐ **I am opting out of my Employer's insurance plan due to religious beliefs.**

☐ **I am opting out of my Employer's insurance plan and I am not currently covered elsewhere.** Note that if you waive coverage considered affordable and minimum essential under the Patient Protection and Affordable Care Act (ACA), you **will not qualify for government credits and subsidies** to purchase individual health insurance on the Marketplace.

Note to Group Administrator: Individuals waiving due to other coverage or religious beliefs will not count against your participation requirements. Individuals who are waiving coverage and are not covered elsewhere will count against your company's participation requirements.

SECTION 3 - EMPLOYEE CERTIFICATION & ACKNOWLEGEMENT

- If you waive coverage, you cannot enroll in your Employer's health plan until the next open enrollment, unless you experience a qualified change in status. Examples include: Involuntary loss of other coverage, acquisition of a new dependent through birth, adoption, or marriage. You must request to enroll in your Employer's plan within 30 days of the qualified change in status. If you miss the 30-day enrollment deadline, you may be required to wait until open enrollment.
- I have no expectation of coverage and paid no premium to my Employer after the requested cancellation/waiver date.

Employee Name (Print): _____ Employer/Group Name: _____

Employee Date of Birth: _____

Employee Social Security #: _____ Employer/Group Number: _____

I certify I have read and understand the above "Waiver Release" information. I have provided these answers as part of the application procedure required by the issuer to waive coverage and I certify that all information completed on this form is true, correct and complete. I understand that the insurance carrier 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 purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

All Sections of this form must be filled out completely. Incomplete forms will be returned.

Signature of Employee: _____ **Date**: _____

Signature of Employer's Authorized Contact: _____ **Date**: _____

Please return this form to EPK & Associates, Inc. 15375 SE 30th Place, Suite 380, Bellevue, WA 98007
Phone: 425-641-7762; Fax (425) 641-8114