HRI HEALTH RESEARCH INCORPORATED®

WAIVER OF COVERAGE

Employee Name:_____ EMP ID _____

I acknowledge that I am eligible to enroll in NY State Health Insurance Program (NYSHIP) group health insurance coverage for myself and my dependents through Health Research, Inc. (HRI)

For the plan year effective___/___/___I am waiving enrollment
(MM/DD/YY)

I am waiving coverage due to:

☐ My preference is not to have coverage

☐ Coverage under my spouse's/domestic partner's plan

Company Name:_____

Name of carrier:_____

☐ Other coverage

Name of carrier:_____

This other coverage is: ☐ Individual ☐ COBRA ☐ Medicare ☐ TRICARE(formerly CHAMPUS)

☐ Medicaid ☐ Employer-Sponsored Group Plan

Special Enrollment Notice and Certification – Please review and sign below if you wish to waive coverage

If you are declining enrollment for yourself or dependents (including your spouse) because of other health care coverage, you may enroll yourself and your eligible dependents in the HRI Health Insurance Program in the event that your other health care coverage ends, provided that HRI Human Resources receives your enrollment within 30 days after the date that your other coverage ends. In addition, if you have new dependents as a result of marriage, birth, adoption, or placement for adoption, you may request to enroll yourself and your eligible dependent(s), provided that HRI Human Resources receives your enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you choose to enroll in coverage offered by HRI at a later date and do not experience a qualifying event, or if you submit your enrollment request more than 30 days following a qualifying event, there will be a 3-month delay in the start date of your coverage.

By signing below, I certify that I have been given an opportunity to apply for coverage for myself and my eligible dependents, if any (including my spouse). I am declining enrollment as indicated above.

_____ _____

Signature of Employee Date of Signature