

## Waiver of Medical Coverage NAPEBT Group Medical Plan

I have received and read a copy of the "Important Plan Information for NAPEBT Participants", which includes information on Special Enrollment Rights and Preexisting Condition Exclusions (the Notice).

Initial

\_\_\_\_\_ I am waiving my rights and the rights of my eligible dependents for coverage under the NAPEBT Group Medical Plan (the Plan).

\_\_\_\_\_ I have other coverage under a qualified group employer's plan that is **not** through another NAPEBT employer, which is the reason I am declining coverage under the Plan.

\_\_\_\_\_ I have attached an enrollment confirmation or a written statement on company letterhead from the benefits department of the other employer's plan verifying I am covered under their plan.

\_\_\_\_\_ I will not be allowed to change my benefit election until the next regular open enrollment unless I have a Special Enrollment event as described in the Notice and notify my Human Resources Department within 31 days (in most cases).

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Last 4 of Social Security #

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date