TOWN OF MILFORD

DEPARTMENT OF HUMAN RESOURCES

Employee Name:	
Address:	
City, St, Zip	

2023 Waiver of Group Health Benefits/Group Dental Benefits & Notice of Special Enrollment Rights

STEP 1

Please complete the following: **EFFECTIVE**: 01/01/2023 - 12/31/2023 or as of: _____ (date)

STEP 2

☐ **Waiver of Group Health Benefits**

Medical, HealthTrust – Group #362223

For: ☐ Myself ☐ Spouse ☐ Dependent (select all that apply)

I am waiving coverage due to:

- ☐ My preference not to have coverage
- ☐ Coverage under my spouse's/domestic partner's plan – name of carrier: _____
- ☐ Other coverage – name of carrier: : _____

This other coverage is: Individual ☐ COBRA ☐ Medicare ☐ TRICARE (formerly CHAMPUS) ☐ Medicaid ☐ Employer-Sponsored Group Plan

STEP 3

☐ **Waiver of Group DENTAL Benefits**

DENTAL, HealthTrust – Group # 3116

For: ☐ Myself ☐ Spouse ☐ Dependent (select all that apply)

I am waiving coverage due to:

- ☐ My preference not to have coverage
- ☐ Coverage under my spouse's/domestic partner's plan – name of carrier: _____
- ☐ Other coverage – name of carrier: : _____

STEP 4

☐ **I have attached proof of coverage of other insurance (must provide)**

☐ **I have PREVIOUSLY attached proof of coverage of other insurance and nothing has changed.**

Please print double-sided

Notice of Special Enrollment Rights

Special Enrollment Notice and Certification – *Please review and sign below if you wish to waive 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. I am declining enrollment as indicated above. I understand that I am declining enrollment for myself or my eligible dependents (including my spouse) because of other health insurance or group health plan coverage, or other dental insurance or group dental plan coverage. I may be able to enroll myself and my eligible dependents in this plan if I lose, or my eligible dependents lose, eligibility for that other coverage (or if the employer stops contributing towards my or my eligible dependents' other coverage).

I understand that I must request enrollment **no more than 30 days after the date the other health plan coverage ends** (or after the employer stops contributing toward the other coverage). If I do not do so, I will not be able to enroll until my employer's next annual open enrollment period.

In addition, I understand that if I have a newly eligible dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my eligible dependent(s). However, **I must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.**

I understand that in order to request special enrollment or obtain more information, I should contact my group administrator.

STEP 5

Signature of Employee | Date of Signature

Employee File

Please print double-sided