Health Benefits Waiver Form

County of Union employees that elect to waive insurance coverage must complete this form. Do not submit an enrollment form for any benefit being waived.

Part 1

Employee Information:

Social Security #:		Department:	
Last Name:		Home Address:	
First Name:	M.I.	City: State:	Zip:
Date of Hire:		Date of Birth:	Male____ Female____
Effective Date:		Marital Status:	

Part 2

Benefit Selection:

Please select the benefit plan(s) that you will be waiving participation. Employees that are waiving the medical coverage are required to provide proof of alternate coverage, such as an insurance card.

- ☐ All Benefits (medical, prescription, dental, and vision)
- ☐ Medical
- ☐ Prescription
- ☐ Dental
- ☐ VSP

Part 3

I hereby voluntarily waive participation in the benefit plans that I have selected on this form. I understand that I can only enroll and make changes to my health benefits during an open enrollment period or within 30 days of a qualifying life event.

_____ _____

EMPLOYEE SIGNATURE DATE

Updated: November 2023