Minuteman Health™

Waiver of Coverage Form

Company Name: _____

Employee Name: _____

Date of Birth: _____

☐ **I waive health coverage for myself and dependents (if any).**

Reason for Declining Coverage:

- ☐ I am covered through my spouse's employer
- ☐ I am covered through parent's health plan
- ☐ I am 65 or over and covered by Medicare
- ☐ I am covered by the NH Medicaid Program
- ☐ I am covered by another health plan offered by my company
- ☐ I am covered by another health plan offered by a second employer
- ☐ I am covered by a veterans program
- ☐ I am covered by a non-group health plan
- ☐ I do not wish to participate at this time
- ☐ I live in the town of _____ that is not in the Minuteman Health service area
- ☐ Other; please specify: _____

Employer Name: _____

Insurance Carrier: _____

I affirm that the information I have provided on this form is true and correct to the best of my knowledge.

_____ _____

Employee Signature Date