Waiver of group coverage - Illinois

2650 Novation Parkway • Fitchburg, WI 53713-3399
(800) 362-3310 • Fax (608) 643-2564
QuartzBenefits.com

Group name:	Group number:
Employee name:	Employee Social Security number:

You may decline health coverage offered by your employer. This is called a waiver of coverage. If you waive coverage for yourself, you may not cover dependents under the Employer's health plan.

I certify that I have been given the opportunity to apply for the Quartz group health benefit plan coverage for which I am eligible. I decline to enroll for such coverage. I understand that I may be able to obtain coverage at a later time for reasons listed in the Notice of Special Enrollment Rights. If circumstances in the Notice of Special Enrollment Rights do not apply, then I and/or the persons listed above may be able to apply for coverage at Open Enrollment. I certify that the information is, to the best of my knowledge and ability, complete and true.

I am waiving coverage for:

☐ Myself ☐ Spouse or partner in civil union ☐ Children or other eligible dependents

I am waiving group health insurance because:

☐ I/we will be covered under another health benefit plan that is not sponsored by my employer.

Name of insurance co.:_____

☐ Other reason for waiving:_____

_____	_____	_____
Name of employee (please print)	Employee's signature	Date