

# Flex Plan Waiver Form

## *Flexible Benefit Plan*

---

Employer \_\_\_\_\_

Employee Name \_\_\_\_\_

Social Sec#: \_\_\_\_\_

Mailing Address \_\_\_\_\_

Birth Date: \_\_\_\_\_

\_\_\_\_\_

Hire Date: \_\_\_\_\_

### **Waiver of Medical Insurance Coverage**

I desire to waive my employer-sponsored medical insurance coverage.

To be eligible to waive this “core coverage” benefit under the terms of my employer’s Flexible Benefit Plan, I certify that I am covered by a “substantially equivalent group insurance policy”, meaning:

- 1) I am covered by a group policy sponsored by another employer or by a Medicare Supplement,
- 2) The coverage is substantially equivalent to the coverage I wish to waive,
- 3) The coverage is now in force and will remain in force for the indefinite future,
- 4) I will promptly notify my employer if such coverage is discontinued, which may create a “qualifying event” allowing me to enroll for coverage under the plan I am now waiving.

I am providing evidence of having such substantially equivalent insurance coverage in force by means of the following certification(s). I understand that my employer’s Benefit Administrator must, under the terms of the Flexible Benefit Plan, obtain reasonable proof that I am so covered.

\_\_\_ Policy Booklet outlining coverage (to determine that coverage is “substantially equivalent”).

\_\_\_ Proof that coverage is now in force. This proof is in the form of

\_\_\_\_\_.

Employee Signature \_\_\_\_\_

Date \_\_\_\_\_

Employer Signature \_\_\_\_\_

Date \_\_\_\_\_