WAIVER FORM

REFUSAL OF COVERAGE

1. If you are not enrolling at this time, your next opportunity to enroll will be at the next open enrollment for your employer's group insurance plan unless you have a qualifying event, such as loss of current coverage or marriage. See your employer for more information on qualifying events.
    a. NOTE: If you do not elect STD at the time you are first eligible, you will not be able to enroll without going through medical underwriting at a later date.
2. If you are not enrolling your dependents at this time, they will not be eligible for enrollment until your employer's next annual open enrollment unless they have a qualifying event such as loss of other coverage. See your employer for more information regarding dependent qualifying events.
3. If you are not enrolling at this time, complete and sign the waiver section below.

I decline the coverage indicated below. I understand my dependents and I may not be eligible to enroll for benefits until my employer's next annual open enrollment period. I and/or my dependents may become eligible to enroll if here is a qualifying event, and I request enrollment within 30 days of the eligible qualifying event.

HEALTH CARE

Employee	Dependent Spouse	Dependent Child(ren)
☐	☐	☐

REASON FOR WAIVING: ☐ COBRA ☐ Sopusal Coverage ☐ Fed. Exchg. Coverage ☐ State Exchg. Coverage ☐ Other Group/Indv. Coverage ☐ Medicare/ Medicaid/ Military

☐ WAIVE DENTAL ONLY ☐ WAIVE VISION ONLY ☐ WAIVING BOTH

Employee	Dependent Spouse	Dependent Child(ren)
☐	☐	☐

REASON FOR WAIVING: ☐ COBRA ☐ Sopusal Coverage ☐ Fed. Exchg. Coverage ☐ State Exchg. Coverage ☐ Other Group/Indv. Coverage ☐ Medicare/ Medicaid/ Military

SHORT TERM DISABILITY (STD)

Employee	Dependent Spouse	Dependent Child(ren)
☐	N/A	N/A

By signing below I acknowledge my waiver of benefits offered by my employer iTech Solutions, Inc. and that I have received, read and reviewed the attached Affordable Care Act notice.

Employee Signature ______________________________

Employee Name ______________________ Date ______________

Company Name iTech Solutions, Inc.

Note: If your employee is not enrolling for any coverage at this time, or is declining enrollment for any dependents, keep a copy of the waiver in your files.