



# Washington Counties Insurance Fund Waiver of Medical Coverage

I received and read a copy of the "Notice of HIPAA Special Enrollment Rights and Consequences of Declining Coverage" (the "Notice") at or before the time I was initially offered enrollment in group health plan benefits under Washington Counties Insurance Fund (WCIF). I am aware of the warning in the Notice that I will lose some special enrollment rights for myself and my dependents (including my spouse\*) if I decline coverage, unless I give my employer this written statement that the reason I am declining coverage is because I or my dependents have other comparable coverage. Furthermore, I understand the warnings regarding the consequences of waiving coverage and that WCIF and its affiliated carriers are not liable for any claims I may incur when I am not enrolled and participating in a WCIF medical plan.

By signing this form, I decline coverage under WCIF for the people listed below. My reason for declining coverage for these people is that they have other comparable coverage under another group health plan or health insurance. I have named the other coverage that is in effect for each person listed, along with the member number or subscriber number for each person.

*(List all the people whom you could cover under a WCIF medical plan but are not covering because they have other comparable coverage, including you, your spouse\* and your dependents, if applicable. Use additional paper if necessary.)*

Name: \_\_\_\_\_ Other Coverage: \_\_\_\_\_  
Member/Subscriber Number: \_\_\_\_\_

Name: \_\_\_\_\_ Other Coverage: \_\_\_\_\_  
Member/Subscriber Number: \_\_\_\_\_

Name: \_\_\_\_\_ Other Coverage: \_\_\_\_\_  
Member/Subscriber Number: \_\_\_\_\_

Name: \_\_\_\_\_ Other Coverage: \_\_\_\_\_  
Member/Subscriber Number: \_\_\_\_\_

Name: \_\_\_\_\_ Other Coverage: \_\_\_\_\_  
Member/Subscriber Number: \_\_\_\_\_

Name: \_\_\_\_\_ Other Coverage: \_\_\_\_\_  
Member/Subscriber Number: \_\_\_\_\_

Signature: \_\_\_\_\_

Name (Print): \_\_\_\_\_

Date Signed: \_\_\_\_\_

\* or Qualified Domestic Partner