



Waiver of Group Health Benefits

Employee Name: _____

Date: _____

Department: _____

Position: _____

I acknowledge I have been offered the opportunity to enroll myself and eligible family members in Pittsylvania County's Group Health Plan for the plan year effective October 1, 2020.

I decline enrolling myself or eligible family members (including spouse) in the group health plan coverage because:

I have other medical coverage provided by:

Insurance Company Name: _____

Policy/Group Number: _____

Through (Employer Name): _____

I do not wish to enroll myself at this time.

I do not wish to enroll any eligible family member at this time.

Special Enrollment Notice and Certification – Please review and sign below if you wish to waive coverage.

By signing below, I certify that I have been given an opportunity to apply for coverage for myself and my eligible dependents, if any. I am declining enrollment as indicated above. I may be able to enroll myself and my eligible dependents in this plan due to a qualifying event (marriage, divorce, birth, adoption, loss of other coverage). Special enrollment due to a qualifying event must be requested no more than 30 days after the date of the qualifying event.

I understand that I should contact Human Resources to obtain information regarding special enrollment.

Employee Name: _____ (printed)

Employee Signature: _____

Date: _____