EMPLOYEE'S WAIVER FORM

Section 1: GROUP INFORMATION

Group Name	Policy Number / Group ID

Section 2: EMPLOYEE INFORMATION

Employee Name (First Middle Last)

Employee Date of Hire	Employee average number of hours worked per week	Waiving Coverage For:
		☐ Myself ☐ My Spouse ☐ My Child(ren)

Section 3: WAIVING COVERAGE INFORMATION

I have been offered coverage under my groups plan through the Idaho Lawyer Benefit Plan (The "Plan") but am not enrolling for the following reason:

☐ I do not wish to enroll myself and/or my dependants in group insurance at this time.

☐ I currently have other qualifying coverage elsewhere:
Carrier ____ Policy Number ____________________________

Policy Type: ☐ Group ☐ Individual ☐ Medicaid ☐ Medicare

☐ Other Reason(s) to Waive Coverage ____________________________

I understand that if I decline the coverage for myself or eligible family members, and then choose to apply for coverage at a later date, The Plan may exclude coverage, or may limit coverage to exclude preexisting conditions, not to exceed 12 months, except in the following circumstances:

A. The individual meets each of the following:

   1. Was covered under qualifying previous coverage at the time of initial enrollment;
   2. Loses employer contribution towards the qualifying previous coverage;
   3. Lost coverage under qualifying previous coverage as a result of termination of employment or eligibility, the involuntary termination of the qualifying previous coverage; and
   4. The individual requests enrollment within thirty (30) days after termination of the qualifying previous coverage.

B. The individual is employed by and employer that offers multiple health benefit plans and the individual elects a different plan during an open enrollment period;

C. A court has ordered that coverage be provided for a spouse or minor or dependent child under a covered employee's health benefit plan and request for enrollment is made within thirty(30) days after issuance of the court order;

D. If an individual seeks to enroll a dependent during the first sixty (60) days of eligibility, the coverage of the dependent shall become effective:

   1. in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;
   2. in the case of a dependent's birth, as of the date of such birth; or
   3. in the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

The Plan will apply creditable coverage for the period of time an individual was previously covered by a qualifying previous coverage, provided the qualifying previous coverage was continuous to a date not more than sixty-three (63) days prior to the effective date of the new coverage.

I understand that I and/or my dependents will be unable to obtain coverage under The Plan until the next annual enrollment period, unless I and/or my dependants qualify for a special enrollment as prescribed above in items A through D.

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Signature of Employee Date