City of Newport News
Employees' Benefits Office
700 Town Center Dr., Suite 200
Newport News, VA 23606

Waiver of Group Health, Dental, & Vision Benefits & Notice of Special Enrollment Rights

Employee Name: _____ **SSN or EIN:** _____

I am waiving coverage for:

☐ **Health only** ☐ **Dental only** ☐ **Vision only** ☐ **Health, Dental & Vision**

Employee Date of Hire: _____ / _____ / _____ . I am waiving coverage for:
(MM DD YY)

☐ Myself
☐ Spouse
☐ Dependent (s) – Please list names: _____

I am waiving coverage due to:

☐ My preference not to have coverage

☐ Coverage under my spouse's plan – name of carrier: _____

☐ Other coverage – name of carrier: _____

This other coverage is: ☐ Individual ☐ COBRA ☐ Medicare ☐ TRICARE (formerly CHAMPUS)
☐ Medicaid ☐ Employer-Sponsored Group Plan

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 understand that I am declining enrollment for myself or my eligible dependents (including my spouse) because of other health/dental insurance or group health/dental plan coverage. I may be able to enroll myself and my eligible dependents in this plan if I lose, or my eligible dependents lose, eligibility for that other coverage (or if the employer stops contributing towards my or my eligible dependents' other coverage).

I understand that I must request enrollment no more than 30 days after the date the other health/dental plan coverage ends (or after the employer stops contributing toward the other coverage). If I do not do so, I will not be able to enroll until my employer's next annual open enrollment period.

In addition, I understand that if I have a newly eligible dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my eligible dependent(s). However, I must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

I understand that in order to request special enrollment or obtain more information, I should contact the Benefits Office.

_____ _____
Signature of Employee Date of Signature