Sutter Health Plus
Your Health Plan

Employee Health Care Waiver of Coverage Form

All current and future employees who are waiving coverage with SHP must complete the following sections(s) where applicable, sign and date. Please return to SHP at the address listed at the bottom of this form. Failure to do so may prevent you from enrolling with SHP outside of your group's open enrollment period.

Employer/Applicant Information	
Employer Name:	SHP Group Policy ID Number:
Employee Name:	Employee Date of Hire:

Waiver of Coverage (Please elect any that apply)

☐ I voluntarily waive all coverage's provided by my employer through Sutter Health Plus.

Reason(s) for waiver of coverage (please check any that apply):

☐ I am covered under my spouse's/domestic partner's group plan.

☐ I am covered under an individual plan.

☐ I do not want the coverage's selected above.

☐ I am covered under another group plan.

☐ I am covered under a Medicare plan.

☐ I am covered under a Medi-Cal Plan

☐ Other (provide details):

____

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Other Insurance Information (if additional space is needed, please provide on a separate sheet)

Other Insurance Company Name: ___________________________ Policy Number: _____________

Policyholder/Subscriber's Name: ____________________________ Member ID Number: _________

I understand that by voluntarily waiving coverage, neither I nor my dependents including my spouse, are eligible to apply for coverage under Sutter Health Plus until my employer's open enrollment period, unless I become eligible by a qualifying event.

____

Signature | Printed Name (First and Last) | Date

Please return this completed form to:

Sutter Health Plus
P.O. Box 162295
Sacramento, CA 95816
Fax: 916-736-5426