mda health plan
MDAPROGRAMS.COM

Employee Waiver Form

This form is required for all **eligible employees** who are not enrolling in the MDA Health Plan at the time of initial enrollment, employment and/or the group's open enrollment period. If you have any questions or need assistance while completing this form, please call 1-877-906-9924 and press 1.

Employee Information

Employee Name ***(last, first, initial)***	**Employer Name**

If you are waiving coverage offered by your employer, please complete the following section.

☐I am covered under another group health plan not offered by this employer.

Carrier Name _____ Policy Number _____

☐I have other coverage through my spouse or other family member.

Carrier Name _____ Policy Number _____

Policyholder Name _____ Relationship to Employee _____

☐I have individual coverage through another source that is not employer-sponsored or employer-paid.

Carrier Name_____ Policy Number _____

☐I have individual subsidized coverage through the Federal Marketplace.

☐I have no other coverage but choose not to enroll in my employer's plan.

The information provided above is true and accurate to the best of my knowledge. I understand that I will not be eligible for coverage through the MDA Health Plan until my employer's next open enrollment period unless I qualify for coverage due to a HIPAA qualifying event (such as marriage, birth of a child, adoption, or loss of other coverage).

Employee Signature	**Today's Date**