Verification of Alternative Coverage

TUFTS Health Plan

Please fill out this form completely if you are waiving coverage.

Employee information

Employee Name: _____

Social Security Number: _____

Employer Group: _____

Reasons for waiver of coverage

I waive my right to participate in Tufts Health Plan offered at this time by or through my employer because:

- ☐ I am covered under my spouse's health plan.
- ☐ I am covered under another health plan sponsored by my company.
- ☐ I am covered by Medicare.
- ☐ I do not wish to participate at this time.
- ☐ Other: (Must provide details)

_____

_____

_____

Signature

If you are declining enrollment for yourself or for your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in Tufts Health Plan, provided that you request enrollment within 30 days after your coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself as well as your dependents, provided you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

I understand that if I later choose to enroll, I must meet Tufts Health Plan's requirements, if any, applicable to late enrollees.

Name: _____

Signature: _____ Date: _____