



KELLY & ASSOCIATES INSURANCE GROUP, INC.

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WAIVER OF EMPLOYER SPONSORED HEALTH PLAN

This waiver must be completed, signed, and dated by any full-time employee who is currently eligible for coverage with your group and who has voluntarily chosen to waive his/her opportunity to participate in the employer-sponsored group insurance plan. The employer should also keep a copy of this waiver on file. This information is very important to have in order to satisfy the group insurance underwriting and participation guidelines.

Please type or print:

Employer:	Account Group #		
Employee's Name:			
Last	First		Middle Initial
Social Security Number:	Date of Birth:	Date Employed:	
_____	____/____/____	____/____/____	
I and my eligible dependents are covered under (please check one and fill out appropriate information below):			
<input type="checkbox"/> a group medical plan issued through my spouse's employer.*			
<input type="checkbox"/> an Individual Market plan.			
<input type="checkbox"/> Military/VA Benefits.			
<input type="checkbox"/> Medicare/Medicad.			
<input type="checkbox"/> Do not currently have health coverage.			
*Spouse's Employer (If Applicable):		Carrier:	
I hereby certify that the medical benefits provided by my Employer have been explained to me, and that I have been given an opportunity to apply for the insurance, and that I voluntarily decline to participate in the plan. I understand that if I choose to enroll at a later date, my cost may be higher, a health questionnaire may be required and/or the effective date of my coverage may be delayed.			
Employee Signature:			Date:
_____			_____