



CHARTER HEALTH PLAN
A big idea for small business

Coverage Waiver

1. Employee Information		Group Name:	
Last Name, First, MI:	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married	Date of Birth: / /	<input type="checkbox"/> Divorced
Home Address:	Apt. #:	City, State:	Zip Code:

2. Declining Coverage:

Reason:

- Covered by spouse's employer's plan
- Covered by Individual Insurance
- Covered by Medicare
- Other(explain): _____

By signing this form, you acknowledge that you will not be eligible to join the Plan until your employer's next anniversary date (open enrollment) unless you have a qualifying Family Status change.

Employee's Signature _____ Date _____