Employee Medical Coverage Waiver Form

Employee Name:

Employee ID:

Department:

I hereby acknowledge that I have been given the opportunity to enroll in the company's medical coverage plan. I understand the benefits provided; however, I choose to waive my right to participate in the company's medical coverage for the current plan year.

☐ I acknowledge and voluntarily waive my medical coverage.

Reason for Waiver (optional):

Employee Signature:

Date:

Submit