Medical Benefits Declination Agreement

I, _____, acknowledge that I have been offered medical benefits by _____ (Employer).

I hereby **decline** to participate in the medical benefits plan at this time. I understand that by declining, I am waiving my right to employer-sponsored health benefits until the next open enrollment period or unless I experience a qualifying life event.

Reason for Declination (optional):

_____

I acknowledge that I have received information regarding the available benefits and have had the opportunity to ask questions.

Employee Signature: _____

Date: _____

Employer Representative: _____

Date: _____