

Priority Health Employee Waiver Form

Reform Groups (2-50 eligible employees)

This form is required for all eligible employees who are not enrolling with Priority Health at the time of initial enrollment and/or during the group's open enrollment period.

I understand that I am eligible for Priority Health coverage through my employer and that my employer is contributing at least 75% of the single rate or 50% of my total premium.

I waive the right to enroll with Priority Health as offered to me by my employer for the following reason: (please check one)

- I have other coverage offered by my employer.
- I have other coverage through my spouse or other family member.
- I have other coverage through Medicare or a pension plan.
- I have individual coverage through another source that is not employer sponsored or employer paid.
- I have no other coverage but choose not to enroll in my employer's plan.

I understand that I will not be eligible for coverage through Priority Health until my employer's next Open Enrollment period unless I qualify for coverage due to a HIPAA qualifying event (such as - marriage, birth of a child, adoption, loss of other coverage)

Employee Name Printed

Employee Signature Date

Employer Signature Date

Group Name Priority Health
Group Number

In accordance with the Genetic Information Nondiscrimination Act (GINA) of 2008, Priority Health requests that you not include any genetic information on this form. Genetic information includes any genetic testing results of either yourself or a family member, your family health history or any requests for or receipt of genetic services.