



NOTICE OF ENROLLMENT PERIOD AND WAIVER FORM

Employer Name: _____

Effective Date: _____

If you are declining coverage for yourself or for your dependents (including your spouse) under this plan because you have health coverage, you may in the future be able to enroll yourself or your dependents in this plan. Your request for enrollment must be submitted to Atlantis Health Plan within 30 days after your other coverage involuntarily ends.

In addition, if you are not enrolled under your employer's group health plan and you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. Your request for enrollment must be submitted to Atlantis Health Plan within 30 days after the event.

If you are declining coverage, please check one of the following reasons.

- I am declining coverage because I have coverage through my spouse.**
- I am declining coverage because I am enrolling in coverage option my employer offers.**
- I am declining coverage because I choose not to participate; I understand that I will not be eligible to enroll in this plan until open enrollment period.**

Employee Signature

Date

Printed Name