Bethany Benefit Service

P.O. Box 316560, Chicago, Illinois 60631
Fax: (773) 784-2249 | Email: bethany@covchurch.org

Waiver of Health Insurance

Instructions: Fill out and return this form to Bethany Benefit Service.

I am aware that Bethany Benefit Service has extended medical, dental, vision and prescrition benefits to me (and my family), and I understand that I am only eligible to waive these benefits if I am covered by another employer's health insurance policy (my spouse's employer or a second job of my own) or the Marketplace. I understand that if I waive coverage at this time and wish to apply at a later date, I may need to wait until open enrollment.

1. YOUR INFORMATION

Name: _____ SSN: _____

Effective Date of Change: _____ /_____ /_____ (Coverage will continue until the end of the given month.)

2. TYPE OF CHANGE

I hereby waive the following benefits:

- ☐ **Medical and prescription**
- ☐ **Dental and vision**

Check one:

- ☐ **for myself and all eligible dependents** (please complete the following)

  We/I have health covereage through:
  - ☐ **another employer** (name of employer: _____)
  - ☐ **the Marketplace** (name of insurance company: _____)
- ☐ **for all eligible dependents**

3. AUTHORIZED SIGNATURE

This form, signed by the policyholder, is to request the cancellation of the benefits indicated above.

Signature: _____ Date: _____ /_____ /_____