



Instructions: Fill out and return this form to Covenant Benefits.

I am aware that Covenant Benefits has extended medical, dental, vision and prescription 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 coverage 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: ____ / ____ / ____