



PRIORITY HEALTH

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 50% of my total premium or 100% of my single 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 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 (including getting married, having a child or involuntarily losing my other coverage).

Employee Signature _____ Date _____

Employer Signature _____ Date _____

Group Name _____ Group Number _____

Please FAX to Priority Health Small Business Department @ 616 957-2529