

# RHODE ISLAND VERIFICATION OF ALTERNATIVE COVERAGE

Please fill out this form completely if you are waiving coverage.

## Employee Information

Employee Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Employer Group: \_\_\_\_\_

## Reasons for Waiver

I waive my right to participate in Tufts Health Plan offered at this time by or through my employer because:

- I am covered under my spouse's health plan.
- I am covered under another health plan sponsored by my company.
- I am covered by Medicare.
- I am covered by COBRA.
- I do not wish to participate at this time.
- Other: (Must provide details) \_\_\_\_\_

Who is waiver for (Please check all that apply):       Employee       Spouse       Child/Children

## Signature

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if 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. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact your employer.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date