Hometown Health

WAIVER OF HEALTH COVERAGE BENEFITS

All the sections on this form must be completed and signatures are required from employee and employer.

SEE INSTRUCTIONS ON PAGE 2

EMPLOYER INFORMATION

Name of Employer _____

Address _____

City _____ State _____ Zip _____

Telephone _____

APPLICANT / EMPLOYEE INFORMATION

Last Name _____ First Name _____ Middle Initial _____

Address _____

City _____ State _____ Zip _____

Social Security Number _____ Date of Birth (mm/dd/yyyy) _____

Date of Hire _____ Job Title _____

OTHER COVERAGE INFORMATION

Do you have other health benefit coverage?

☐ ***YES*** – If Yes, please complete below

☐ ***NO*** – I do not have other health insurance coverage

Coverage Information

Name of primary person on policy _____

Name of Employer or the Party providing health care coverage _____

Name(s) of dependent(s) covered on policy _____

Name of health plan provider / insurer _____

PLEASE ATTACH A PHOTOCOPY OF YOUR HEALTH PLAN PROVIDER ID CARD.

VALIDATION OF WAIVER OF BENEFITS

*I understand that I have been offered group health insurance by my employer, with Hometown Health. I have elected **NOT** to enroll myself, and/or my dependent(s). I understand that if I and/or my dependent(s) decide, at some time in the future, that I (we) desire this coverage, I must wait for my employer's "open enrollment' period, or special enrollment period due to qualifying event. (i.e.: Divorce, marriage, birth of child, death, loss of medical insurance, etc).*

Employee Signature _____ Date _____

Employer Signature _____ Date _____

Comments _____

Hometown Health

INSTRUCTIONS

ALL THE SECTIONS ON THIS FORM MUST BE COMPLETED
and signatures are required from employee and employer.

EMPLOYER INFORMATION

1. Enter company data in the appropriate Employer information areas.

APPLICANT / EMPLOYEE INFORMATION

1. Enter your personal data in the appropriate Applicant / Employee information areas.

OTHER COVERAGE INFORMATION

1. Please indicate if you do or do not have other health benefit coverage.
2. Please indicate the name of both the Employer, the primary member holding this insurance coverage and the insurance carrier providing you and/or your dependents with the coverage.
3. Attach a photocopy of the Plan Provider ID card.

VALIDATION OF WAIVER OF BENEFITS

1. **EMPLOYEE**
   Read the statement carefully, then sign and date the Waiver of Coverage Form. Please return the form to your employer.
2. **EMPLOYER**
   Please sign form before returning to Hometown Health.

10315 Professional Cir. · Reno, NV 89521 · 775-982-3232 · hometownhealth.com