PUBLIC EDUCATION HEALTH TRUST WAIVER FORM

2550 Denali St, STE 1614, Anchorage, AK 99503
907-274-7526 Fax: 907-222-2556

SOCIAL SECURITY NUMBER	EMPLOYER	SCHOOL

WAIVER OF COVERAGE DUE TO OTHER HEALTH INSURANCE INFORMATION

If Yes: ________________________________ ________________ ____________ ______________
Health Insurance Company Name Group Name Policy Number Phone Number

Names of those covered under other policy: ____

EMPLOYEE'S NAME AND ADDRESS	HOME PHONE	WORK PHONE
	BIRTH DATE	DATE OF HIRE
	SEX:	

Waiver

Effective: / /

Waivers can only be accepted at the time of hire, or during open enrollment (June)
Unless a qualifying event has occurred in the members' household.

WAIVER OF COVERAGE: I acknowledge that I have been given the opportunity to participate in the PUBLIC EDUCATION HEALTH TRUST and that I elect not to participate. I understand that by declining to participate in the Plan at this time I also waive my ability to participate in the future except upon the occurrence of a special enrollment event, or as otherwise provided under the Plan.

SIGNED: _X____ DATE: _X____________________________

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