Health Benefits Waiver Form for Plan Year Beginning July 1, 2025

Group name: Acadia Parish Health Insurance Plan		
Employee name: *Last*	*First*	*Middle Initial*
Date of birth:	**Social Security Number:**	
Location (School or Department):		

I was given the opportunity to enroll in a group insurance health plan offered by my employer

(Note: Benefits provided on a noncontributory basis cannot be refused.)

I am declining to enroll for the reason shown below:

- ☐ Covered by spouse's/domestic partner's group coverage
  - Carrier Name and Member ID _____
- ☐ Enrolled in another Insurance Carrier Plan
  - Carrier Name and Member ID _____
- ☐ Covered by Medicare
- ☐ Covered by TRICARE or CHAMPVA
- ☐ Other *(Please explain)* _____

I acknowledge I have been given the opportunity to apply for this medical coverage. However, I am electing not to enroll. By declining this group health coverage, I acknowledge that I and my dependents (if any) may have to wait until the plan's next anniversary date to enroll for group health coverage.

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Employee Signature Date