

TEXAS  
WAIVER OF MEDICAL COVERAGE

If you are eligible for the group medical coverage offered by your employer and choose not to take it, Texas state law requires that Aetna U.S. Healthcare obtain the following information. **AFTER COMPLETING THE FORM**, please **HAVE YOUR EMPLOYER** send this form to Aetna U.S. Healthcare via mail to your Employers' Services Address shown in the Customer Service Information Section of your Employer's Group Benefits Administration Manual.

Employee Name (last, first):  
Employer Name:

Employee Soc. Sec. No.:  
Control-Suffix-Account:

*Please check and complete the appropriate statement below:*

I have been offered group medical coverage by my employer. I am declining this coverage for myself and my eligible dependents because

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OR

I have been offered group medical coverage by my employer. My fully completed enrollment application is stapled to this form. However, the following eligible dependents are declining this coverage.

Dependent's Full Name

Relationship

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Dependent coverage is being declined because

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I understand that if I waive current coverage, any future application for coverage MAY be subject to Special Enrollment provisions, or if I am deemed a "late enrollee," enrollment may be postponed until the next late entrant enrollment period or next open enrollment period, and I may be subject to the plan's pre-existing condition limitation (maximum 12 months).

I and/or my dependents have made this decision of my/their own accord, with no pressure or coercion from my employer, my employer's agent, or the insurance carrier.

Employee's Signature \_\_\_\_\_

Date \_\_\_\_\_