COCONINO COUNTY ARIZONA

Waiver of Medical Coverage
NAPEBT Group Medical Plan

I have received and read a copy of the "Important Plan Information for NAPEBT Participants", which includes information on Special Enrollment Rights and Preexisting Condition Exclusions (the Notice).

Initial

_____ I am waiving my rights and the rights of my eligible dependents for coverage under the NAPEBT Group Medical Plan (the Plan).

_____ I have other coverage under a qualified group employer's plan that is **not** through another NAPEBT employer, under Medicare or a qualified public health plan such as AHCCCS, which is the reason I am declining coverage under the Plan.

_____ I have attached proof of other coverage such as a copy of the Identification card, an enrollment confirmation, or a written statement on company letterhead from the benefits department of the other employer's plan verifying I am covered under their plan.

_____ I will not be allowed to change my benefit election until the next regular open enrollment unless I have a Special Enrollment event as described in the Notice and notify my Human Resources Department within 31 days (in most cases).

_____ _____

Print Name | Last 4 digits of Social Security Number

_____ _____

Employee's Signature | Date

Please return this completed form to your Human Resources Department Representative.