

# WAIVER OF GROUP MEDICAL COVERAGE FORM

11/06



**NIPPON LIFE INSURANCE  
COMPANY OF AMERICA**  
650 8<sup>th</sup> Street  
Des Moines, Iowa 50309

Please return this completed form to:

Total Plan Services, Inc.  
14001 Dallas Parkway North, Ste 700  
Dallas, Tx 75240  
1-800-969-5238

This form is to be used for declining medical coverage only.

Home Street	Employer
Employee	Social Security Number

I hereby certify that I have been given an opportunity to apply for Group Medical Coverage issued by Nippon Life Insurance Company of America. I understand that medical coverage is available and that I decline this coverage. Check all boxes that apply.

I decline medical coverage for:

Myself

My spouse                      Name of spouse: \_\_\_\_\_

My children                      Name of children: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Reason for waiving medical coverage: I and/or my dependents already have medical coverage under:

Individual Plan

Government Plan

Spouse's Group Plan

Other \_\_\_\_\_

I understand that if I decline medical coverage under this plan, my dependent(s) are not eligible for any coverage for which I am not insured.

Employees who decline medical coverage for themselves and/or their dependents during the initial enrollment period and then, more than 31 days later, request coverage will be considered to be late enrollees. Late enrollees may be subject to an 18 month pre-existing condition limitation.

**Late Enrollee Exceptions**

An eligible employee will not be considered a late enrollee for employee and/or dependent coverage (and coverage will not be deferred) if: (a) late enrollment is made under one of the circumstances below, and (b) any required information or proof is furnished.

1. Termination of Other Health Coverage: request for enrollment is made within 31 days after termination of Other Health Coverage; and (a) the employee certifies that enrollment under this plan was initially declined solely due to the Other Health Coverage, and (b) termination of the Other Health Coverage is due to involuntary termination of employment or eligibility, the involuntary termination of the previous coverage, death of a spouse or divorce.
2. Marriage: Request for enrollment is made within 31 days after the marriage has occurred.
3. Court Order: Request for enrollment is made within 31 days after Issuance of a Court Order that coverage be provided for the spouse and/or minor child(ren) of a covered employee.
4. Election of Different Plan During Open Enrollment Period: The employer offers multiple health plans, and request for enrollment under this plan is made during the Open Enrollment Period established for plan election.
5. Birth or Adoption: Request for enrollment is made within 31 days following the birth, adoption, or placement for adoption of a child.

I hereby acknowledge the above warning regarding the consequences of declining medical coverage at my initial enrollment. I declare that the information given on this waiver is correctly recorded, complete and true.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_