HEALTH PROFESSIONS OF MONTANA PLAN & TRUST

PRINT

CLEAR FORM

WAIVE FORM

Group Name: **Date:**

First Name: **MI:** **Last Name:**

Mailing Address: **Phone:**

City: **State:** **ZIP:**

Social Security Number: **E-mail:**

Date of Birth: **Gender:** **Hours Worked / Week:**

DEPENDENT FAMILY MEMBERS

First	M	Last	SSN	Date of Birth	M/F	Spouse/Domestic Partner/Child	Elect Coverage Medical	Dental	Vision
							☐	☐	☐
							☐	☐	☐
							☐	☐	☐
							☐	☐	☐
							☐	☐	☐
							☐	☐	☐

WAIVE OF COVERAGE

I decline to enroll in the health coverage for: ☐ Myself ☐ My Spouse/Dom Partner ☐ My Dependent Child/ren

Reason for waiver ☐ Other Coverage (list plan) _____

☐ Other Reason (explain) _____

I understand that this waiver of coverage may affect the ability of each person listed above to obtain coverage prior to the next Open Enrollment Period unless a Special Enrollment Event occurs (such as loss of certain other coverage, marriage, birth, or adoption) and I notify the Plan, in accordance with the Plan terms.

SIGNATURE OF APPLICANT **DATE**

SIGNATURE OF EMPLOYER **DATE**

EMPLOYER: This waive form has been reviewed by the Employer group to confirm that the employee and/or family members who are waiving coverage meet all eligibility requirements of the HPMPT under the Plan Document and SPD and the Adoption Agreement between the HPMPT and the Employer Group. You may fax to 406-502-1017 or SECURE email this form to ksweeney@hpmpt.org.

IMPORTANT - For HPMPT purposes, please keep this form and any verifying documentation needed on file for a minimum of four years.