HAMPTON VA

Waiver of Group Health Benefits & Notice of Special Enrollment Rights

Employee Name: _____

Employee Number: _____

For the plan year effective 01/01/2021 I am waiving coverage under the City of Hampton's:

☐ **Optima health insurance plan**
☐ **Delta Dental Plan**
☐ **EyeMed Vision Plan**

Special Enrollment Notice and Certification: *Please review and sign below if you wish to waive coverage.*

By signing below, I certify that I have been given an opportunity for coverage for myself and my eligible dependents, if any. **I am declining enrollment in the plan indicated above.**

If you are declining enrollment for yourself or dependents (including your spouse) because of other health care coverage, you may enroll yourself or your dependents in this plan prior to the next open enrollment period (under certain circumstances). To do this, you must have involuntarily lost your other coverage and we must receive your enrollment application ***within 31 days*** *after your other coverage ended. Additionally, if you have new dependents as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and dependents, provided we receive your completed application* ***within 31 days after the marriage, birth, adoption, or placement for adoption.***

Printed Name: _____

Signature: _____ Date: _____