Waiver of Benefits Form

Snohomish County Human Resources

Employee Information		
Last Name	First Name	Date of Hire
Employee ID #	Department	

Acknowledgement

I acknowledge that I have been offered the opportunity to enroll myself and my eligible dependents in Snohomish County's Group Health Plans.

1. I am waiving (or canceling coverage) for the following individuals:

   ☐ Myself ☐ Spouse or Domestic Partner ☐ Children ☐ All

2. I am waiving (or canceling) the following insurance coverage:

   ☐ Medical ☐ Dental ☐ Vision ☐ Basic Life ☐ Supplemental Life ☐ Long Term Disability

3. I am waiving (or canceling) enrollment at this time because:

   ☐ My dependents and/or I have other healthcare coverage.

   ☐ Other Reason: _____

Signature	Date

To Be Completed by Human Resources						
HR Representative:				Effective Date:		
☐ IBEL	☐ IPSN	☐ Regence	☐ Kaiser Permanente	☐ Delta Dental of WA	☐ Willamette	☐ The Hartford