

CIGNA HEALTHCARE OF CONNECTICUT

Waiver/Verification of Alternative Coverage

I, _____, certify that I am an employee of
(Name)

_____ and I am eligible for group health care
(Company)

coverage with this company. I also certify that I am waiving my right to group health care coverage at this time because:

I have current coverage through spouse
 other employer sponsored health plan
 medicare
 I do not wish to carry insurance coverage*

Name (please print)

Signature Date

Signature of Authorized Company Representative Date

**Call a CIGNA Small Business Representative
at 800-456-6575 with any questions.**