Employee Insurance Waiver Form

Employee Information

Name: _____

Employee ID: _____

Department: _____

Contact Number: _____

Insurance Details

Current Insurance Provider: _____

Reason for Waiving Company Insurance:

☐ Already Insured

☐ Cost Concerns

☐ Other: _____

Waiver Acknowledgment

I understand that by waiving company insurance, I forfeit access to all benefits provided under the policy, including medical, dental, and vision coverage.

☐ I agree to the terms and voluntarily decline company-provided insurance benefits.

Confirmation

I confirm that I have reviewed all options and understand the implications of waiving insurance coverage through [Company Name].

Employee Signature: _____

Date: _____

HR Representative Name: _____

HR Representative Signature: _____