



## CERTIFICATION OF OTHER COVERAGE

**Please Note: If you are a new hire, this must be filled out and returned in conjunction with electing benefits on ProvConnect. If you do not waive your medical benefits online you will be given default coverage.**

*Please complete the information below and return this form to your Human Resources Benefits department.*

I elect to waive medical plan coverage through my employer, Providence Health System, for plan year \_\_\_\_\_ and certify that (*check below as appropriate*):

- I am covered by group medical insurance provided through a source other than Providence Health System.
- I am covered by Providence Health System's group medical coverage through my spouse's benefits.

I acknowledge that this election is made in consideration of "Waive" credits that I will receive in my flexible benefits election. I can only withdraw this election and enroll in PHS sponsored medical plans upon changing my medical plan election for a subsequent plan year during the open enrollment period.

*If you are declining enrollment for yourself or your dependents (including your spouse) because of other group health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan following a documented involuntary loss of other coverage, provided that you request enrollment to this plan within 31 days after your other coverage ends.*

Certified:

To the best of my knowledge, the information I have provided is correct and I understand that if I provide false information that I may be subject to disciplinary action up to and including termination of employment.

Employee Name: \_\_\_\_\_ ID# \_\_\_\_\_

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_