**The Episcopal Church Medical Trust**

**Waiver of Health Benefits**

**Employee Information (Employee to Complete):**

Last Name First Name

Street Address Phone Number

City State Zip

**Employer Information (Employer to Complete):**

Employer Name EIN Number

Address Phone Number

City State Zip

**Employee Acknowledgement**

By signing below, I acknowledge

* I have been offered health benefits coverage through the Denominational Health plan from my employer.
* I decline enrollment at this time because I am receiving health benefits through an approved source.
  + Through a spouse’s or partner’s employment
  + Through a government-sponsored program such as Medicaid or TRICARE
  + From a previous employer

Employee Signature Date