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 _____