## AIRPORT QUALITY STANDARDS PROGRAM COVERED EMPLOYEE VOLUNTARY WAIVER OF HEALTH BENEFITS FORM

This voluntary waiver form must be filled out by the employee, if s/he voluntarily chooses to do so.

You have been asked to complete this voluntary waiver form because your employer is requesting a waiver from the program requirement per the QSP to provide health plan benefits to you. Your employer may obtain a waiver from this legal requirement if you currently have health plan benefits.

Even if you have health plan benefits, your employer is required to provide health plan benefits to you, unless you sign this form. If you want your employer to provide you with health plan benefits, do not sign this form. It is illegal for your employer to force or to pressure you to sign this form.

You have the right to cancel or revoke this voluntary waiver at any time. Your revocation must be submitted in writing. If you revoke this waiver, your employer will be required to provide health plan benefits to you, if there is a Qualifying Change in your family status. If there is no Qualifying Change you may not be able to enroll in coverage until at the Annual Enrollment. You may request information on Qualifying Change from your employer and/or employer health plan provider.

I hereby certify that I have health plan ber			
Employee Name:		Phone:	
Address:	City:	State:	
Name of Employer:			
Contact Person:		Phone:	
If you have health plan coverage from and partner and wish to provide a waiver to the			
Name of Employer Providing Health Cov	erage or Person Whose Cove	erage Extends to you:	
	His/her Relationship to You:		
Employer Address:			
Contact Person:		Phone:	
Name of Health Insurance Provider:		Member ID:	
If you have health plan coverage through	some other means, please ex	plain:	
I hereby waive the right to health plan	benefits offered to me by th	ne employer listed above.	
Employee's Signature		Date	