PREMIERE
HEALTHCARE STAFFING, LLC

2024 MEDICAL DECLINATION AND WAIVER FORM

Employee Name: _____ Phone: _____

Facility/Hospital: _____ E-mail: _____

☐ 2024 Open Enrollment - Effective Date _____

☐ New Hire - Effective Date _____

☐ Qualifying Event - Effective Date _____

This form applies to individuals who waive coverage in Premiere Healthcare's group medical plan.

By signing below, I certify that:

I am declining enrollment in Premiere Healthcare's group medical plan. The reason for my declination is as follows:

☐ I have other qualified medical coverage from another source (such as my spouse's employer)

Name of Insurance Carrier: _____

Policy Number: _____

☐ I do not have other qualified medical coverage and I do not wish to enroll in Premiere Healthcare's group medical plan.

I understand that by signing this form, I am waiving participation in Premiere Healthcare's group medical plan for January 1, 2024 – December 31, 2024.

_____ _____

Employee Signature Date