COMMONWEALTH OF MASSACHUSETTS

TOWN OF PLAINVILLE

INSURANCE REFUSAL

Employee Name: _____

Department: _____

Date of Hire: _____

Effective Date: _____

☐ I am covered as a spouse or dependent (circle one) under another group Medical plan.

Employer Name: _____
Insurance Company: _____

☐ I am covered by Medicare, non-group, Veterans program or a secondary employer (circle one):

Insurance Company: _____

☐ I am NOT covered by another Medical insurance and I voluntarily choose not to participate in my employer's group plan at this time.

_____ _____

Employees Signature Date