YOUR LIFE
YOUR CARE
YOUR PEOPLE

MEDICARE ELIGIBLE PPL

BASIC WELLNESS PLAN BENEFIT WAIVER FORM

Employee Name: _____, _____
Print Last Name First Name

Date_____

I am co-employed by Public Partnerships as an employee. I am being auto-enrolled in the PPL Basic Wellness Plan offered by my employer and I decline this coverage.

Duration of Coverage in This Offer: **May 1st – December 31st**

I decline this coverage, because I have coverage from:

☐ **Medicare**
Insurance Name_____ licy Number: _____

(A copy of the Medicare card must be provided in order to opt out)

I certify that all information provided in this form is true and complete. By declining group health benefits, I acknowledge that I may have to wait until the plan's next open enrollment period to request access to the PPL Basic Wellness group coverage.

Print Name_____

Date of Birth_____

Signature_____

Date_____

Please email this waiver form along with a copy of your Medicare card (front and back) to NYPPLHR@PPLFIRST.COM.