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):

Employee's Email Address ____

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
    - From the Marketplace

______________________________ ______________

Employee Signature Date

Form is required for all eligible employees who are declining Medical Insurance enrollment.
Please email signed form to AMartinez@DioceseFL.org

ELECTRONIC FORM