

**SMALL GROUP VERIFICATION OF ALTERNATIVE COVERAGE
MASSACHUSETTS**

Employee Name (Please Print): _____

Social Security Number: _____ - _____ - _____

Employer Group: _____

I waive my right to participate in Tufts Health Plan at this time by or through my employer because:

____ I am covered under my spouse's health plan

____ I am covered under another health plan sponsored by my company

____ I am covered by Medicare

____ I do not wish to participate at this time

____ Other: _____

I understand that if I later choose to enroll I must meet Tufts Health Plan's requirements, if any, applicable to late enrollees.

Name (Please Print): _____

Signature: _____

Date: _____