Metro

600 NE Grand Ave.
Portland, OR 97232-2736
oregonmetro.gov

Waiver of Group Coverage

I confirm by my signature below that I have been offered the opportunity to enroll in Metro's Group Medical and Dental plans and I am waiving the coverage as of my eligibility date. I understand that the plans offered meet the criteria for a Qualified and Affordable Health Plan under the Affordable Care Act for the individual requirement. By signing this waiver, I acknowledge that my group medical and dental coverage is effective as of the date below, and my current coverage is not through other Medicaid, Medicare, TRICARE or Cobra plans.

Print Name: _____

Signature: _____

Date: _____

Employee # : _____

Please provide your contact information below:

Email: _____

Phone Number: _____

Please return this form along with documentation showing proof of your current group coverage to Metro Human Resources or email a scanned copy to Benefits.Help@oregonmetro.gov