



WAIVER ATTESTATION – COVID-19

Name: _____

W# _____

I attest that I am enrolled in, or immediately will enroll in, one of the following types of coverage: (1) employer-sponsored health coverage through the employer of my spouse or parent; (2) individual health insurance coverage enrolled in through the Health Insurance Marketplace (also known as the Health Insurance Exchange); (3) Medicaid; (4) Medicare; (5) TRICARE; (6) Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA); or (7) other coverage that provides comprehensive health benefits (for example, health insurance purchased directly from an insurance company or health insurance provided through a student health plan).

Signature: _____