

WAIVER OF GROUP COVERAGE

Employer Name:	Employer Number:
Employee Name:	Employee Social Security Number:

I have decided not to apply for coverage offered for:
 to terminate coverages as checked, effective: _____

- | | | | |
|---------|---|--|-----------------------------------|
| Medical | <input type="checkbox"/> Employee | <input type="checkbox"/> Spouse | <input type="checkbox"/> Children |
| Dental | <input type="checkbox"/> Employee | <input type="checkbox"/> Spouse | <input type="checkbox"/> Children |
| Vision | <input type="checkbox"/> Employee | <input type="checkbox"/> Spouse | <input type="checkbox"/> Children |
| | <input type="checkbox"/> Life & AD&D | <input type="checkbox"/> Long Term Disability | |
| | <input type="checkbox"/> Dependent Life | <input type="checkbox"/> Short Term Disability | |

Reason for waiving medical coverage:

- I am covered or will be covered under another plan that is not sponsored by my employer. Please complete carrier information below.
- My dependents are covered or will be covered under another plan that is not sponsored by my employer. Please complete carrier information below.

Carrier information:

Carrier Name: _____

Policy Number: _____

Effective Date: _____

- I will be or am enrolled in another similar plan offered by my employer.
Name of Insurance Company: _____
- My annualized medical premium contribution exceeds 10% of my annualized gross earnings.
- Other: _____

Important information about waiving medical coverage:

I certify that I have been given the opportunity to apply for (or continue) the group coverage and decline to enroll as checked on behalf of myself and/or my dependents. I understand that by signing this waiver, I forfeit my right to coverage. If in the future I apply for coverage I may be subject to an exclusion for pre-existing conditions for a period of 18 months. This period may be offset by time covered under a qualified plan.

I understand that if I am declining enrollment for myself or my dependents (including my spouse) because of other health insurance coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 30 days after my other coverage ends. In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I understand that I may be able to enroll myself and my dependents provided that I request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. The 9 month pre-existing limitation period that is in my policy may be offset by time served in a qualified plan.

Important information about waiving Life and AD&D, Dependent Life, LTD, STD, Vision or Dental:

I certify that I have been given the opportunity to apply for (or continue) the Employer group coverage offered me and decline enrollment as checked on behalf of myself and/or my dependents. I understand that by signing this waiver, I forfeit my right to the coverage without evidence of insurability. If I should decide later that I want to apply, I may do so: HOWEVER, MY LATER enrollment form IS SUBJECT TO THE FOLLOWING LIMITATIONS AND CONDITIONS:

1. Evidence of insurability will be required by the insurance company entirely at my own expense; and
2. Review of my application is conditional and at the sole discretion of the insurance company.
3. Approval of my application and effective date for coverage is at the sole discretion of the insurance company.
4. Late applicants for Vision and Dental are not subject to evidence of insurability, but are subject to approval by The Insurance Company and conditions of the contract.

Signature of Employee Waiving Coverage _____
Date

Authorized Signature of the Employer _____
Date