Waiver of Group Coverage

Group Name: _____ **Group Number:** _____
(Hereafter referred to as the "Company")

I elect not to participate in the Company's Group Health Plan ("the Plan"). I acknowledge that I have been offered the opportunity to participate in such Plan and that I have been given access to sufficient information about the Plan to enable me to make an informed decision regarding participation. I have decided to decline this offer and waive coverage for:

_____ Myself (and eligible dependents if applicable) medical and/or dental coverage.

_____ My eligible dependents only – medical and/or dental coverage.

Reason for waiving coverage:

_____ I have other coverage through _____
(Carrier)

_____ Spouse and/or eligible dependents have other coverage.

_____ Other (please explain _____
_____
_____

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll you or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, adoption or placement for adoption.

An eligible person and/or dependents who did not enroll for coverage under the policy during the initial eligibility period or open enrollment, will be subject to a 12-month exclusionary period beginning on the date of the application. An eligible person and/or dependents are also subject to a 6-month pre-existing medical condition limitation beginning on the first day the person became covered under the policy.

Employee Name (Please Print): _____

Employee Signature: _____

Employee Social Security Number: _____

Date: _____