Waiver and Declination of Coverage Form

DISCLAIMER: I, and/or my dependents, have been given the opportunity to apply for group coverage through the ***Multi Benefit Plans***. I, and/or my dependents, do not wish to enroll for the reason(s) stated below. ***Please carefully read each section before completing and signing***.

Waiver of Coverage

I understand that I (the employee) may only waive/refuse coverage if I have other group coverage in effect. If my other coverage cancels due to termination of employment or cancellation of the plan, my eligible dependents and I may apply for this group coverage. I understand that I would have to apply for the *Multi Benefit Plans* group coverage within 30 days of termination of my prior coverage. The effective date of coverage would be the first of the month following the date my prior coverage terminated.

I am waiving/refusing coverage for:

- ❑ Dental ❑ Vision ❑ Dental & Vision

- ❑ Myself and all dependents if any
- ❑ All of my dependents only
- ❑ Only dependent(s) listed

Name of plan where I and/or my dependents have other coverage:

Employee Signature **Date**

Declination of Coverage

I understand that I (the employee) may decline the *Multi Benefit Plans* group coverage for myself and dependents for when the following circumstances apply:

- **I may decline coverage for my dependents for any reason.**
- **I may decline coverage for myself, if my employer does not pay 100% of the premium.**

I further understand that if I decline coverage, I (and my dependents) may not enroll in the *Multi Benefit Plans* until my employer's open enrollment period, which is the 30 days prior to the employer's anniversary

I am declining coverage for:

- ❑ Dental ❑ Vision ❑ Dental & Vision

- ❑ Myself and all dependents if any
- ❑ All of my dependents only
- ❑ Only dependent(s) listed

Reason(s) for declining coverage:

Employee Signature **Date**