

## WAIVER OF EMPLOYEE GROUP INSURANCE

All employees who have worked at least 90 days and who are employed on a full time basis are eligible for group health insurance. Any employee who is covered under another insurance plan, ie: spouse, parents, medicare, medicaid, etc., or any employee who chooses to decline enrollment upon eligibility must sign a waiver form.

EMPLOYER & LOCATION:		ACCOUNT/GROUP NUMBER:	
EMPLOYEE'S NAME: LAST	FIRST	MIDDLE	
SOCIAL SECURITY NUMBER:	DATE OF BIRTH:	DATE OF EMPLOYMENT:	
<input type="checkbox"/> I AND MY ELIGIBLE DEPENDENTS ARE COVERED UNDER A GROUP MEDICAL PLAN ISSUED THROUGH MY SPOUSE, PARENT OR LEGAL GUARDIAN			
INSURED'S EMPLOYER:	INSURED'S INSURANCE CARRIER:		
I hereby certify that the medical benefits provided by my Employer have been explained to me, that I have been given an opportunity to apply for the insurance and that I voluntarily decline to participate in the plan.			
I understand that if I request coverage for myself and/or my eligible dependents at a later date, I am required to furnish, at my own expense, evidence of each person's eligibility.			
EMPLOYEE SIGNATURE:		DATE:	