# 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 eligiblity 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: |

☐ 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: |
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| | |

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 eligiblity.

| EMPLOYEE SIGNATURE: | DATE: |
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