

## WAIVER CARD FOR GROUP INSURANCE PLAN

EMPLOYEE'S NAME (First, Middle, Last)	DATE EMPLOYED	POLICY NO.
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EMPLOYER NAME \_\_\_\_\_

I hereby certify that the benefits provided under the group insurance plan made available 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 later wish to become insured, it will be necessary that I furnish evidence of insurability satisfactory to the Insurance Company. **Please mark coverages you are waiving.**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Employee Life              | <input type="checkbox"/> Dependent Spouse Life           | <input type="checkbox"/> Dependent Children Life           |
| <input type="checkbox"/> Employee Disability Income | <input type="checkbox"/> Dependent Spouse Dental/Optical | <input type="checkbox"/> Dependent Children Dental/Optical |
| <input type="checkbox"/> Employee Dental/Optical    | <input type="checkbox"/> Other: _____                    |  |

I/My dependent(s) have other coverage under another Group Plan with \_\_\_\_\_  
(Name of Insurer and/or Employer)

**Or;**

I/My dependent(s) have no other coverage under any other Group Plan with.

I understand that if I decide to enroll for such insurance at a later date, coverage for myself and/or my dependents may be subject to satisfactory evidence of insurability or delay Dental Expense Benefits if applicable. Waivers are effective first of the month following receipt by the Insurance Company.

DATE	SIGNATURE OF EMPLOYEE
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