

Waiver of Health, Dental and/or Vision Coverage

I acknowledge that I have been offered the opportunity to purchase health and dental coverage for myself and my dependents through my employer.

I am waiving enrollment for: Dental Health Vision

I decline enrollment at this time because:

- I have other coverage provided by: _____
- I do not wish to enroll myself in any type of coverage at this time.
- I do not wish to enroll my spouse and/or child(ren) in any type of coverage at this time.

If you are declining enrollment for yourself or dependents (including your spouse) because of other health care coverage, you may enroll yourself or your dependents in this plan prior to the next open enrollment period. Under certain circumstances, you may enroll yourself or your dependents outside of open enrollment if you have involuntarily lost your other coverage. To do this, we must receive your enrollment application within 30 days after your other coverage ended.

Additionally, if you have new dependents as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and dependents, provided we receive your completed enrollment application within 30 days after the marriage, birth, adoption, or placement for adoption.

Printed name: _____

Signature: _____

Date: _____