

Group Benefits Waiver Form

Section 1 Employee Information

Please print clearly

Name of Employer

Client No.

Name of Employee

I, the undersigned, acknowledge I have been offered the group benefits available under my employer's program. These benefits have been fully explained and I have decided to decline the benefits indicated below.

- All Benefits**
- Life Insurance
- Accidental Death & Dismemberment
- Dependent Life Insurance
- Weekly Indemnity
- Long Term Disability
- Extended Health Care
- Dental Care
- Optional Life Insurance
- Spousal Optional Life Insurance
- Optional Accidental Death & Dismemberment

Section 2 Authorization

I understand that if I wish to join the group benefits program at some future date, I will have to provide at my own expense, medical evidence of insurability (proof of good health) satisfactory to the insurance company for myself and my dependents (if applicable). I further understand that I and/or my dependents may be denied coverage at that time by the insurance company.

I hereby release my employer, the insurer(s), and the administrator from any responsibility for lack of coverage at some future date, which is caused by my declination at this time.

Please sign here

Employee Signature

Date (yyyy/mm/dd)

Employer Signature

Date (yyyy/mm/dd)