

Waiver (Refusal) of Group Insurance Benefits

please print clearly

Name of Employer:
Client Number:
Name of Employee:

<p>I, the undersigned, acknowledge I have been offered the group insurance benefits available under my employer's program. These benefits have been fully explained and I have decided to decline the benefits indicated below.</p>		
<input type="checkbox"/> All Benefits	<input type="checkbox"/> Life Insurance <input type="checkbox"/> Accidental Death & Dismemberment <input type="checkbox"/> Dependent Life Insurance <input type="checkbox"/> Weekly Indemnity <input type="checkbox"/> Long Term Disability	<input type="checkbox"/> Extended Health Care <input type="checkbox"/> Dental Care <input type="checkbox"/> Optional Life Insurance <input type="checkbox"/> Spousal Optional Life Insurance <input type="checkbox"/> Voluntary Accidental Death & Dismemberment

Reason for Declination:

<p>I understand that if I wish to join the plan 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 dependants (if applicable). I further understand that I and/or my dependants may be denied coverage at that time by the Insurance Company.</p> <p>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.</p>	
Employee's Signature:	Employer's Signature:
Date (yyyy/mm/dd):	Date (yyyy/mm/dd):