

WAIVER FORM
(Please print in ink)



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1-800-795-1023

Employer Name		Division/Location	
Employee Last Name		First Name	Middle Initial
Social Security Number	Date of Full Time Employment (mm/dd/yyyy)	Email Address	

REASON FOR WAIVING COVERAGE

- I am waiving coverage for myself
- I am waiving coverage for my spouse
Name of Spouse _____
- I am waiving coverage for my Dependent(s)

Dependent Name (First / Middle / Last)	Relationship

DECLINE TO PARTICIPATE

I certify that I have been given the opportunity to participate in the health care plan offered by my employer and have declined to participate. I have declined to participate for the following reason (check one).

- Another plan offered by employer
- My spouse's group coverage
- An individual plan
- A government plan (type) _____
- COBRA or State Continuation
- I and/or my dependents are currently not covered by any other health care plan
- Other (please explain) _____

I understand that if I elect to apply for coverage for myself, my spouse, and/or my dependent children through this health care plan at a later time, the application will be subject to the Summary Plan Description of my employer's Health Care Plan.

Employee Signature _____ Date