

Section 8: Waiver/Declining coverage**Medical coverage****Medical** coverage declined for – check all that apply:**Reason for declining coverage** – check all that apply:

- ☐ Myself ☐ Spouse/domestic partner ☐ Dependent(s)
☐ Covered by spouse's/domestic partner's group coverage
☐ Enrolled in other insurance – Please provide company name and plan: _____
☐ Enrolled in individual coverage
☐ Spouse covered by employer's group medical coverage
☐ Medicare/Medicaid/VA
☐ Other – please explain: _____
☐ No coverage

Dental coverage**Dental** coverage declined for – check all that apply:**Reason for declining coverage** – check all that apply:

- ☐ Myself ☐ Spouse/domestic partner ☐ Dependent(s)
☐ Covered by spouse's/domestic partner's group coverage
☐ Enrolled in other insurance – Please provide company name and plan: _____
☐ Enrolled in individual coverage
☐ Spouse covered by employer's group medical coverage
☐ Medicare/Medicaid/VA
☐ Other – please explain: _____
☐ No coverage

Vision coverage**Vision** coverage declined for – check all that apply:**Reason for declining coverage** – check all that apply:

- ☐ Myself ☐ Spouse/domestic partner ☐ Dependent(s)
☐ Covered by spouse's/domestic partner's group coverage
☐ Enrolled in other insurance – Please provide company name and plan: _____
☐ Enrolled in individual coverage
☐ Spouse covered by employer's group medical coverage
☐ Medicare/Medicaid/VA
☐ Other – please explain: _____
☐ No coverage

Life and disability coverage***Life/AD&D** coverage declined for:

Spouse, Domestic Partner and dependent coverage not available if life coverage is waived/declined.

Dependent Life coverage declined for:**Supplemental/Voluntary** coverage declined for:**Supplemental/Voluntary Dependent Life** coverage declined for:**Voluntary Short Term Disability** coverage declined for:**Voluntary Long Term Disability** coverage declined for:**Reason for declining coverage** – check all that apply:

- ☐ Myself
☐ Spouse/domestic partner and dependents
☐ Myself
☐ Spouse/domestic partner and dependents
☐ Myself
☐ Myself
☐ Life/AD&D declined for religious reasons
☐ Do not elect to enroll in Dependent Life
☐ Do not elect to enroll in Supplemental/Voluntary coverage
☐ Do not elect to enroll in Supplemental/Voluntary Dependent Life coverage
☐ Do not elect to enroll in Voluntary Short Term Disability
☐ Do not elect to enroll in Voluntary Long Term Disability

*I hereby certify that I have been given the opportunity to apply for the available group life benefits offered by my employer, the benefits have been explained to me, and I and/or my dependent(s) decline to participate. Neither I nor my dependent(s) were induced or pressured by my employer, agent, or life carrier, into declining this coverage, but elected of my (our) own accord to decline coverage. I understand that if I wish to apply for such coverage in the future, I may be required to provide evidence of insurability at my expense.

Sign here only if you are declining coverage.

Signature of applicant

Printed name

Social Security no.

Date (MMDDYYYY)

X