

Association Master Trust

GROUP HEALTH BENEFITS WAIVER OF COVERAGE

Group Number _____

Employer Name _____

Employee Name: _____
(Last) (First) (MI)

Id#: _____

Marital Status: () Single () Married () Widowed () Divorced

Date of Birth _____ Date of Employment _____

I was given the opportunity to enroll into the group health benefit plan offered by my employer

I refuse the following:

- () Employee, Spouse and Child(ren) Coverage
- () Spouse Coverage
- () Child(ren) Coverage

Reason for Refusal (Please check all appropriate boxes):

- () Other group coverage sponsored by my spouse's employer
- () Other group coverage sponsored by another organization
- () Other reasons (please explain) _____

Please provide the name of the other carrier and policy number _____

I understand that if I later wish to enroll for any of the coverage(s) refused, I will be required to submit an Enrollment Form and that I may be subject to a preexisting conditions exclusion.

Employee Signature Date

Witness Signature Date