

WAIVER OF COVERAGE

The group **medical program** has been offered to me, and after carefully considering its benefits, I have decided:

- (a) not to enroll myself in the Medical Program
 - (1) I was covered as a Dependent Spouse in another Group Plan when I became eligible for this Plan.
 - (2) I had other Creditable Coverage when I became eligible for this Plan.
 - (3) I do not have other Creditable Coverage

I understand that if I elect not to enroll in the **group medical program** at this time I will not be permitted to enroll at a later date unless:

- (1) A person becomes my dependent through marriage, birth, adoption or placement for adoption and I request enrollment for myself and my dependent(s) within 31 days of such event; **OR**
- (2) each of the following conditions is met:
 - (a) I have declined this coverage on the basis of item (a)(1) or item (a)(2) above; and
 - (b) my coverage is terminated as a result of loss of eligibility for the coverage (for reasons other than fraud or failure to pay premiums); and
 - (c) I request enrollment within 31 days of the loss of coverage.

- (b) not to enroll my dependents in the Medical Program
 - (1) My Dependents are covered in another Plan
 - (2) My Dependents are not covered in another Plan

I understand that if I elect not to enroll my eligible Dependents in the **group medical program** at this time I will be permitted to enroll them at a later date only if each of the following conditions is met:

- (1) I am a participant under this Plan; and
- (2) A person becomes my Dependent through marriage, birth, adoption or placement for adoption (all other Dependents must be enrolled at the same time) **OR** I had waived coverage on the basis of item (b)(1) above and my Dependent or Dependents lose coverage as a result of loss of eligibility under that coverage; and
- (3) I request enrollment of such person or persons within 31 days of the qualifying event.

I understand that if the other coverage is lost as a result of the failure to pay premiums or required contributions or for cause (such as making a fraudulent claim) these options will not be granted.

Employee Signature

Date Signed

Employee Printed Name