

**REFUSAL OF GROUP COVERAGE**  
(Please complete all areas to refuse coverage)

Employee Name:

\_\_\_\_\_

Last	Middle Initial	First
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Employer Name:

\_\_\_\_\_

Social Security Number:

\_\_\_\_\_

Reason for Refusal of Coverage:

\_\_\_\_\_

If coverage is being refused because of other coverage, please indicate name of insurance company providing coverage: \_\_\_\_\_

I have been given the opportunity to apply for enrollment in the Plan provided by my employer. The benefits have been explained to me and I understand them fully. After serious consideration, I have decided not to take advantage of this offer **FOR MYSELF AND MY DEPENDENTS**. As a result, I waive all claims to benefits payable thereunder for myself and/or my dependent(s). Further, I understand and agree that should I wish to participate in this plan at some future date, I will be required to furnish evidence of insurability, which is subject to approval by your employer's carrier before life and medical coverages can become effective, and that my dependents and myself will be subject to any applicable pre-existing condition exclusions.

\_\_\_\_\_  
Employee's Signature (In Ink)

\_\_\_\_\_  
Date