

DECLINATION

Employee Name: _____ Social Security #: _____

Check which coverage declined. Medical Dental Employee ID#: _____

Occupation: _____ Birth Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Marital Status: _____ Sex: M F Hire Date: _____

NOTE: You must complete this form if you are waiving (declining) insurance coverage available to you through your Employer.

This is to certify that I have been given the opportunity to apply for group coverage available to me and my dependents pursuant to state law through my Employer. I proclaim that I was not pressured or forced by my Employer into waiving (declining) the above noted coverage. I understand that in the event that I should decide to apply for such coverage, hereafter, that such subsequent applications shall be subject to the applicable terms and conditions of the Master Group Contract.

Date: _____ Employee Signature: _____