WAIVER FORM
(Please print in ink)

PO Box 24042
Winston-Salem, NC 27114-4042
(336) 774-4400 Fax: (336) 760-3028
1-800-795-1023

Employer Name	Division/Location

Employee Last Name	First Name	Middle Initial

Social Security Number	Date of Full Time Employment (mm/dd/yyyy)	Email Address

REASON FOR WAIVING COVERAGE

☐ I am waiving coverage for myself

☐ I am waiving coverage for my eligible dependents

Dependent Name (First / Middle / Last)	Relationship	Date of Birth (mm/dd/yyyy)

DECLINE TO PARTICIPATE

☐ I certify no other person(s) is in my household that should have coverage waived other than those listed above.

☐ I certify that I have been given the opportunity to participate in the health care plan offered by my employer and have declined to participate. I have declined to participate for the following reason (check one).

- ☐ Another plan offered by employer
- ☐ My spouse's group coverage
- ☐ An individual plan
- ☐ A government plan (type) ______________________________
- ☐ COBRA or State Continuation
- ☐ I and/or my dependents are currently not covered by any other health care plan
- ☐ Other (please explain) ______________________________

I understand that if I elect to apply for coverage for myself, my spouse, and/or my dependent children through this health care plan at a later time, the application will be subject to the Summary Plan Description of my employer's Health Care Plan.

______________________________ ______________________
Employee Signature Date