Waiver of Coverage

This form must be completed if you have declined coverage for yourself or your dependents.

Do you or your dependents have other health insurance under a group plan, HMO, PPO, POS, or Medicare? □ Yes □ No

Please √ the box(es) to indicate the coverage you and/or your dependents have under any other employer's group plan:

□ **Medical**

Type of Coverage_____ Insurance Company & Policy #_____

□ **Dental**

Type of Coverage_____ Insurance Company & Policy #_____

Please **print** your name:

_____

Participant's name

_____

Participant's signature Date