



HEALTH BENEFIT WAIVER

This benefit waiver is available to employees who are regularly scheduled to work a minimum of 24 hours or more every week. Upon renewal of the Group Health Plan, employees may elect to continue to waive out or enroll in the benefit program during the open enrollment period, or at any time upon a qualifying event as defined in the Plan's Summary Plan Description.

WAIVER

I, _____ voluntarily agree to waive coverage under the health benefits offered by _____. I understand the above explanation of my rights to waive benefits or enroll in the benefit program offered.

Choose one of the below options that apply:

I knowingly do not have any type of health (medical, vision & prescription drug) benefits and do not wish to participate in the Group Health Plan being offered.

I certify that I am covered by the following health insurance plan:

Name of Health Insurance Plan: _____

Company or Group Sponsor: _____

I understand that if I purchase individual health insurance, it must not be paid for with pre-tax dollars, and any contribution from my employer toward my health insurance will be considered part of my salary and taxed as such.

Employee Signature: _____ Date: _____

Employer Signature: _____ Date: _____

<p>Account # _____</p> <p>To be completed by Plan Administrator</p>
