CBIA HEALTH CONNECTIONS

Waiver Form

Refusal of Coverage

I decline the coverage indicated below. I understand my dependents and I may not be eligible to enroll for benefits until my employer's next annual open enrollment period. I and/or my dependents may become eligible to enroll if there is a qualifying event, and I request enrollment within 30 days of the eligible qualifying event.

	Employee	Dependent Spouse	Dependent Child(ren)
Medical	❑	❑	❑
If waiving medical, my coverage is: (check all that apply)			
Other group coverage	❑	❑	❑
Military, Medicare/Medicaid coverage	❑	❑	❑
Coverage through individual state exchange	❑	❑	❑

If you do not elect Life, STD or LTD at the time you are first eligible, you will be required to submit a Personal Health Application (PHA) for approval prior to your coverage becoming effective.

	Employee	Dependent Spouse	Dependent Child(ren)
Life	❑	N/A	N/A
Supplemental Life	❑	N/A	N/A
Dependent Life	N/A	❑	❑
Short-term Disability	❑	N/A	N/A
Long-term Disability	❑	N/A	N/A

_____ _____

Employee Signature Date

_____ _____

Print Name Company Name

Note to employer: If your employee is not enrolling for any coverage at this time, or is declining enrollment for any dependents, keep a copy of this waiver in your files.