IDA Insurance Design Administrators

WAIVER OF GROUP COVERAGE

1) Group Name

2) Employer's Name & Address

3) Employee's Name (last, first, middle init.) 4) Social Security No.

5) Are participants covered under another Group Health Plan? [ ] Yes [ ] No

If yes: [ ] Employee [ ] Spouse only [ ] Spouse & child(ren) [ ] children only

If a Dependent is covered by another Group Health Plan, please give:

6) Name of Dependent(s) 7) Social Security No.

8) Dependent's Employer & Address

9) Health Carrier or Insurance Company & Address (medical) 10) Group No.

11) Health Carrier or Insurance Company & Address (dental) 12) Group No.

13) Prescription Drug Company & Address (prescription drug card plan) 14) Group No.

15) Vision Carrier or Company & Address (vision) 16) Group No.

I have been advised of the opportunity to participate in my Employer's Group Health Plan and hereby acknowledge that coverage will not be provided for me as outlined, because I (we)

[ ] waive coverage (see below)

Employee Coverages:

17)
[ ] All Benefits
[ ] Medical Benefits*
[ ] Dental Benefits*
[ ] Life
[ ] Accidental Death & Dismemberment
[ ] Short Term Disability
[ ] Long Term Disability
[ ] Prescription Card Service*
[ ] Vision Benefits*

Dependent Coverages:

18)
[ ] spouse only
[ ] spouse & child(ren)
[ ] child(ren) only

[ ] All Benefits
[ ] Medical Benefits*
[ ] Dental Benefits*
[ ] Life
[ ] Accidental Death & Dismemberment
[ ] Short Term Disability
[ ] Long Term Disability
[ ] Prescription Service Card*
[ ] Vision Benefits*

I understand that if I later request to participate in this Plan for any of the above coverages provided, it is on a condition that the request is in writing to the Plan Sponsor and Plan Administrator. Participation in this Plan may be afforded persons who have waived coverage and request enrollment either during Open Enrollment, if offered; for an effective date so designated by the Plan Sponsor or during a Special Enrollment Period. I also understand that if I or any dependent(s) do not fulfill the eligibility requirements under this Plan, the Employer has the right to refuse the request for Health Benefit Plan enrollment.

Employee Signature Date