

Name of Employer Association or Union _____

Employee's Name _____ SS# _____

Marital Status: Single Married Divorced Widowed

Number of eligible dependent children _____

I was given the opportunity to enroll in this plan of group insurance offered by my employer and I am refusing contributory medical coverage due to:

Coverage by another employer sponsored health plan

Spousal coverage

Answer if you are refusing employee, spouse and/or child medical coverage:

Are your dependents now covered by any other group plan? Yes No

If yes, please indicate:

Policyholder's Name _____ **Carrier Name** _____

(Your dependents may be insured by this plan although they are covered elsewhere.)

I understand that if I do not enroll at this time I must wait until the next open enrollment period.

Signature of Employee

Date

Signature of Witness

Date