WAIVER FORM

NCLM LIFE & HEALTH INSURANCE

Employer Name		Division/Location
Employee Last Name	First Name	Middle Initial
Social Security Number	Date of Full Time Employment (mm/dd/yyyy)	Email Address

REASON FOR WAIVING COVERAGE

☐ I am waiving coverage for myself

☐ I am waiving coverage for my spouse

Name of Spouse_____

☐ I am waiving coverage for my Dependent(s)

Dependent Name (First / Middle / Last)	Relationship

DECLINE TO PARTICIPATE

I certify that I have been given the opportunity to participate in the health care plan offered by my employer and have declined to participate. I have declined to participate for the following reason (check one).

☐ Another plan offered by employer

☐ My spouse's group coverage

☐ An individual plan

☐ A government plan (type) _____

☐ COBRA or State Continuation

☐ I and/or my dependents are currently not covered by any other health care plan

☐ Other (please explain) _____

I understand that if I elect to apply for coverage for myself, my spouse, and/or my dependent children through this health care plan at a later time, the application will be subject to the Summary Plan Description of my employer's Health Care Plan.

_____ _____

Employee Signature Date