THERMOCOAX

Group number: _____

Waiver of Group Vision Benefits and Notice of Special Enrollment Rights

Instructions: Please complete boxes outlined in **RED**

A: Please Complete the Following:

Employer Name:

Employee Information:

Last Name: Middle Initial: First Name:

Social Security Number:

For the plan year effective: __/__/____

I am waiving coverage for (check all that apply):

- ☐ Myself
- ☐ Spouse/Domestic Partner
- ☐ Dependent(s) – Please list names: _____

_____

I am waving coverage due to (check all that apply):

- ☐ My preference not to have coverage
- ☐ Coverage under my spouse's/domestic partner's plan – name of carrier and plan:

_____

- ☐ Other Coverage – name of carrier and plan: _____

This other coverage is: ○ Individual ○ COBRA ○ Medicare ○ Medicaid ○ Employer-Sponsored Group Plan

B: Special Enrollment Notice and Certification

I hereby certify I have been given the opportunity for the available group dental benefits offered by my employer. The benefits have been explained to me, and I and/or my dependent(s) have declined to participate. Neither I nor my dependent(s) were induced or pressured by my employer, agent or dental carrier into declining this coverage, but elected of my (our) own accord to decline coverage.

Signature of Employee: Signature Date: __/__/____