Group number: _____

Waiver of Group Telemedicine 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: Date of Birth: _____/_____/_____

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:

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

B: Special Enrollment Notice and Certification

I hereby certify I have been given the opportunity for the available telemedicine 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: _____/_____/_____