Group number: _____

Waiver of Group Critical Illness 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
- ☐ Cost
- ☐ Other: _____

B: Special Enrollment Notice and Certification

I hereby certify I have been given the opportunity for the available Whole Life 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 Critical Illness carrier into declining this coverage, but elected of my (our) own accord to decline coverage.

Signature of Employee: Signature Date: / /