Admin. Use Only
EWC
DWC
Case #____________

ALLIED NATIONAL
GROUP HEALTH PLAN WAIVER

Waiver For Self

AFTER due consideration, it is my determination not to enroll myself in the Group Health Plan because of (check one):

❑ Existing Coverage - I am covered under another Individual Health Plan or employer-sponsored Health Benefit Plan.

Name of employer (if applicable): ____________________

Name of health plan carrier above: ____________________

Policy, Certificate or Identification Number: ____________________

Telephone Number of Company or Claims Department: ____________________

❑ Other Reasons - I opt not to enroll for coverage for myself in the Group Health Plan due to reasons other than having any existing coverage as listed above. I understand that I have the right to enroll for coverage at this time and am voluntarily declining coverage.

Waiver For Dependents (skip if you do not have dependents)

AFTER due consideration, it is my determination not to enroll my dependents in the Group Health Plan because of (check one):

❑ Existing Coverage - My dependents are covered under another Individual Health Plan or employer sponsored Health Benefit Plan.

Name of employer (if applicable): ____________________

Name of health plan carrier above: ____________________

Policy, Certificate or Identification Number: ____________________

Telephone Number of Company or Claims Department: ____________________

❑ Other Reasons - I opt not to enroll for coverage for dependents in the Group Health Plan due to reasons other than having any existing coverage as listed above. I understand that I have the right to enroll my dependents for coverage at this time and am voluntarily declining coverage.

Important Information

If you are declining coverage for yourself or your dependents (including your spouse) because of other coverage, you may in the future be able to enroll yourself or your dependents in this plan provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

I understand that not enrolling for coverage due to reasons other than having qualifying existing coverage has important consequences:

a. My dependents and I may be excluded from coverage as described in the Late Applicant Eligibility provisions set forth in the Certificate or Summary Plan Description; or

b. The effective date of coverage for myself and my dependents may be delayed, as described in the Late Applicant Eligibility provision in the Certificate or Summary Plan Description; or

c. The period during which pre-existing conditions will not be covered may be extended for myself and my dependents, as described in the Late Applicant Eligibility and Pre-Existing Conditions Limitations provisions in the Certificate or Summary Plan Description.

As a result, I waive all claim benefits payable thereunder for myself and/or my dependents. I understand the above information may be verified in order to determine whether the participation requirements for this group enrollment meets underwriting standards.

Name of Employee (please print): ____________________ Social Security #: ____________________

Name of Employer: ____________________ Case #: ____________________

Signature of Employee: ____________________ Date: ____________________

ALLIED NATIONAL
UNDERWRITING DEPARTMENT
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Electronic copies of this form submitted via facsimile, e-mail, or other electronic means shall be deemed an original.