



## DECLINATION

Employee Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Check which coverage declined.  Medical  Dental Employee ID#: \_\_\_\_\_

Occupation: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Sex:  M  F Hire Date: \_\_\_\_\_

NOTE: You must complete this form if you are waiving (declining) insurance coverage available to you through your Employer.

This is to certify that I have been given the opportunity to apply for group coverage available to me and my dependents pursuant to state law through my Employer. I proclaim that I was not pressured or forced by my Employer into waiving (declining) the above noted coverage. I understand that in the event that I should decide to apply for such coverage, hereafter, that such subsequent applications shall be subject to the applicable terms and conditions of the Master Group Contract.

Date: \_\_\_\_\_ Employee Signature: \_\_\_\_\_