



Waiver or Declination of Coverage Form

DISCLAIMER: I, and/or my dependents, have been given the opportunity to apply for group coverage through the *élan trust*. I, and/or my dependents, do not wish to enroll for the reason(s) stated below. *Please carefully read each section before completing and signing.*

Waiver of Coverage

I understand that I (the employee) may only waive/refuse coverage if I have other group coverage in effect. If my other coverage cancels due to termination of employment or cancellation of the plan, my eligible dependents and I may apply for this group coverage. The effective date of coverage would be the first of the month following the date my other coverage terminated. I understand that I would have to apply for the <i>élan</i> group coverage within 30 days of termination of my prior coverage	
I am waiving/refusing coverage for: <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Dental / Vision	
<input type="checkbox"/> Myself (and all dependents if any)	
<input type="checkbox"/> All of my dependents	
<input type="checkbox"/> Only dependent(s) listed	
Name of Plan where I and/or my dependents have other coverage:	
Employee Signature	Date

Declination of Coverage

I understand that I (the employee) may decline the <i>élan</i> group coverage for ONLY my dependents for any reason. I further understand that if I decline my dependent(s) they will not be eligible for <i>élan</i> DPO Plan coverage at any time in the future. Under the DeltaCare, there is an open enrollment only on the employer's anniversary date.	
I am declining coverage for: <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Dental/Vision	
<input type="checkbox"/> All of my dependents	
<input type="checkbox"/> Only dependent(s) listed	
Reason(s) for declining coverage: (dependents only may decline coverage)	
Employee Signature	Date