HEALTH BENEFITS WAIVER OF COVERAGE

GROUP NAME Flagship One INC

GROUP POLICY NO Flagship One ICHRA

EMPLOYEE NAME ____________ Last ____________ First ____ M.I.

SOCIAL SECURITY # ___ ___ ___

DATE OF BIRTH Month Day Year **DATE OF HIRE** Month Day Year

MARITAL STATUS ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced**

I was given the opportunity to enroll in this plan of group health benefits offered by my employer.

I REFUSE the following:

☐ Health Coverage

REASON FOR REFUSAL (Please indicate all that apply.)

☐ other group coverage sponsored by my employer

☐ other group coverage sponsored by my spouse's employer

☐ other group coverage sponsored by another organization

☐ other-reasons--please explain

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I understand that if I later wish to enroll for any of the coverage(s) refused, I may be denied coverage under the covenants of the group insurance policy or the Plan rules.

Signature of Employee ______________________ Date ____________

Signature of Witness ______________________ Date ____________