BEST
PERSONNEL INC.

HEALTH BENEFITS WAIVER OF COVERAGE

GROUP NAME Best Personnel

GROUP POLICY NO Best Personnel ICHRA

EMPLOYEE NAME _____ _____ _____
Last First M.I.

SOCIAL SECURITY # ___ ___ ____

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

_____

_____

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