WAIVER OF COVERAGE

EMPLOYEE NAME:_____ HIRE DATE: _____

COMPANY:_____ ENROLLMENT DATE: _____

Coverage(s) declined for:

DENTAL: ☐ Myself ☐ Spouse/Domestic Partner ☐ Child(ren)

VISION: ☐ Myself ☐ Spouse/Domestic Partner ☐ Child(ren)

Reason for declining coverage: (please check one)

☐ Covered under another employer health benefit plan (e.g., through spouse, domestic partner)
Carrier Name: _____ Group #: _____ (attach copy of ID card)

☐ Covered under an individual plan through a separate health carrier
Carrier Name: _____ (attach copy of ID card)

☐ Other: _____

☐ FLEXIBLE SPENDING ACCOUNT (FSA) - HEALTH

☐ FLEXIBLE SPENDING ACCOUNT (FSA) - DEPENDENT CARE

☐ 401(K) SAVINGS & RETIREMENT PLAN

☐ FLEXIBLE SPENDING ACCOUNT (FSA) - TRANSPORATION/PARKING

☐ AFLAC VOLUNTARY OPTIONS

☐ COLONIAL LIFE VOLUNTARY OPTION

_____My initials acknowledge I have read the following paragraphs:

I have been notified that I, and any dependents that I may have, are eligible to enroll in any MMC sponsored group health plan coverage. I now decline to enroll in the MMC health plan(s) as indicated above. I am aware that my *next opportunity to enroll will be at the next Open Enrollment period*, unless I experience a Qualifying Event. If I experience a *Qualifying Event*, such as acquiring a new dependent as the result of marriage, birth, adoption or placement for adoption, I acknowledge that I, and any dependents that I may have, may request enrollment in any of MMC's group health plans by applying for that coverage within 30 days of the marriage, birth, adoption, or placement for adoption. If I have indicated above that the reason for declining coverage for myself and/or my dependent(s) is coverage under another health benefit plan, I acknowledge that if these individuals involuntarily lose coverage under the other employer's health benefit plan, I must request enrollment for them in MMC's group health plan *within 30 days*.

X_____ _____

Employee Signature Date