DENTAL and/or VISION WAIVER

(for employer sponsored plans only, not required for voluntary plans)

IMPORTANT!

Complete this page only if you DO NOT WANT DENTAL OR VISION COVERAGE for yourself and/or your eligible dependents (if offered by your employer). If sponsored by your employer, the life coverage, chiropractic coverage, or chiropractic/acupuncture coverage cannot be waived and you are required to complete a Dental / Vision / Chiropractic / Life Enrollment Form.

Personal Information

Company Name: WIRELESS WATCHDOGS

Company Phone # (XXX) XXX-XXXX:

Employee Last Name:

Employee Social Security #:

Employee First Name:

Group #: B 0 5 3 5 0

Type of Waiver

I have been offered coverage by my employer, but at this time I wish to DECLINE coverage as follows

1) **Dental for** ☐ Myself and Dependents ☐ Spouse ☐ Domestic Partner ☐ Child(ren)

2) **Vision for** ☐ Myself and Dependents ☐ Spouse ☐ Domestic Partner ☐ Child(ren)

Reason

Required only if employee waiving coverage — not required if waiving coverage for dependents only

1) **Reason waiving Dental**

☐ Other Group Coverage Carrier Name _____
☐ Medicare
☐ Medi-cal
☐ Individual Policy
☐ Other Reason _____ (explanation required)

2) **Reason waiving Vision**

☐ Other Group Coverage Carrier Name _____
☐ Medicare
☐ Medi-cal
☐ Individual Policy
☐ Other Reason _____ (explanation required)

Signature

☒ **I understand that by waiving coverage now, ChoiceBuilder®can impose up to a 12 month period of exclusion which would begin at the time of my later decision to elect coverage.**

☒ I also understand that if my employer is sponsoring life coverage, chiropractic coverage, or chiropractic/acupuncture coverage, that I CANNOT waive these coverages. **(Steps A-E MUST be completed if these benefits are being sponsored.)**

This waiver provision will not apply if: 1) Court orders coverage of a spouse or child and the request for enrollment occurs within 60 days of the court order; or 2) Employee meets ALL of the following: A) Was covered under another employer-sponsored health plan at the time of initial eligibility; B) Has added a new dependent as a result of marriage, domestic partnership, birth, adoption, or placement for adoption and if enrollment is requested within 60 days after the marriage, domestic partnership, birth, adoption or placement for adoption OR employee or eligible dependents loses minimum health care coverage, for any reason other than due to failure to pay premiums, fraud, or intentional misrepresentation of material fact; C) Requests enrollment within 60 days of loss of coverage.

Employee SIGN HERE TO WAIVE COVERAGE	Print Name	Date (MM/DD/YYYY)
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