

WAIVER OF EMPLOYEE CONVERSION COVERAGE

EMPLOYER: _____

EMPLOYEE: _____

PERSONAL ID NUMBER: _____

I, _____ (print name) am an employee of the Participating Employer identified above and hereby confirm my decision to waive the following conversion coverage for the benefits offered to me. I have had these benefits explained to me and I understand that explanation and the potential consequences to me and to any dependents or beneficiaries of waiving coverage.

By applying my signature opposite each benefit line, I hereby decline the coverage offered to me:

Basic Life Insurance _____

AD&D Insurance _____

Extended Health Care _____

Dental _____

Optional Disability _____

Optional Critical Illness _____

EMPLOYEE ACKNOWLEDGEMENT OF UNDERSTANDING AND AGREEMENT:

I understand the implications of waiving benefit conversion and any questions I have had regarding my waiver of conversion have been answered to my satisfaction. I further understand that:

1. waiving conversion under the Employee Benefit Plan will automatically terminate any benefits I have currently in place;
2. in waiving conversion benefits coverage I will be deemed ineligible for any conversion benefits 31 days after leaving the group plan and I will not have the opportunity to apply for benefit conversion in the future;

EMPLOYEE SIGNATURE: _____ DATE: _____

EMPLOYER ACKNOWLEDGEMENT OF UNDERSTANDING AND AGREEMENT:

We understand that as Employer we must comply with the conversion provisions under the Master Contract and we are allowing this employee to waive coverage under our conversion provision within those limitations and hereby certify we are in compliance with these participation requirements.

EMPLOYER SIGNATURE: _____ DATE: _____