HEALTH CARE EMPLOYEES/EMPLOYER DENTAL AND MEDICAL TRUST

WAIVER / ENROLLMENT POLICY

I acknowledge that I have been given the opportunity to participate in the Health Care Employees/Employers Medical Trust. I am waiving this medical/dental/vision coverage for myself and/or my dependents. I have made this decision voluntarily.

A. HEALTH/DENTAL/VISION PLAN COVERAGE	B. REASON FOR DECLINING:
Check coverage(s) declined: □ Medical □ Dental □ Vision I decline coverage for: □ Myself □ Spouse □ Child(ren) □ Spouse and Child(ren)	Check One: □ Covered by spouse's group coverage Carrier name and ID # _____ □ Spouse covered by employer's group coverage. □ Other (explain) _____ _____ _____

I understand that by choosing to waive/terminate my medical coverage I will not have the right to enroll for benefits again until the following open enrollment period with the exception of a change in life status.

I understand that by choosing to waive/terminate my dental/vision coverage I will not have the right to enroll for benefits again until the open enrollment period which occurs at least one year after the date of this waiver with the exception of a change in life status.

_____ _____

PRINTED NAME OF EMPLOYEE | SOCIAL SECURITY NUMBER

_____ _____

SIGNATURE OF EMPLOYEE | DATE

_____

NAME OF EMPLOYER