

Request for Waiver of Medical/Dental/Vision (Optional Benefits)

When to use this form:

An eligible employee still actively working at your location and is enrolled for Life, LTD, and optional benefits (medical/dental/vision), but now wants to waive (decline) his/her optional benefits. (Refer to "Your Employee Benefit" booklet for eligibility definition)

Location Name _____ Location ID No. _____

Name _____
Please Print Last Name First Name Middle Initial

Soc. Sec. No. _____

I hereby certify that I have requested my employer to waive (decline) my optional benefits. I understand that if I waive (decline) at this time, future coverage may be deferred up to six months and may be subject to preexisting conditions limitation.

Myself My Dependents Medical Dental Vision

You must complete one of the following - Coverage is being waived because:

1. Employee enrolled on spouse's plan
2. Employee enrolled in employer provided HMO
3. Employee covered by another employer
4. Employee has own individual policy
5. Other, please explain _____

Effective Date* _____ Signature of Employee _____ Date _____

Administrator's Approval _____

* This form must be sent within 31 days of the effective date.

Christian Brothers Employee Benefit Services
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