INSURANCE DECLINATION FORM

If you are declining or canceling medical/dental coverage for you and/or your dependents-complete this form. If you have previously declined coverage and would like to enroll under the special enrollment period for a qualifying event, please complete an enrollment form and submit to Human Resources within 31 days of the date of the qualifying event and attach the appropriate documentation.

Location: WAKEFIELD THERMAL SOLUTIONS, PELHAM, NH SIMON INDUSTRIES, CARY, NC
PMES, WATERTOWN, CT MIDWEST ALUMINUM, WITHEE, WI

EMPLOYEE INFORMATION			
LAST NAME	FIRST NAME	HIRE DATE	DATE OF BIRTH
SS#	DEPARTMENT		

INSURANCE DECLINATION

o **Medical Insurance** - I elect to decline and/or cancel Medical Insurance for**:** o Myself o My Dependent(s)

*Effective date _____

o **Dental Insurance** - I elect to decline and/or cancel Dental Insurance for**:** o Myself o My Dependent(s)

*Effective date _____

**If coverage is dropped during an active enrollment period, the cancellation will be effective the next pay period following receipt of this form by Human Resources.*

DEPENDENTS (Please list dependents for whom you are declining coverage):

DEPENDENT`S NAME	RELATIONSHIP	REASON FOR DECLINATION

PROOF OF ALTERNATE COVERAGE REQUIRED

If you are declining coverage, please provide proof of alternate coverage by completing the following information.

Insurance Company: _____ ID#: _____

Coverage Period: _____ Subscriber's Name: _____

***Waiver Authorization* – Important information, please read carefully**

I understand that by declining or canceling medical and/or dental insurance at this time I will not be eligible to enroll my eligible dependents or myself until the next scheduled open enrollment period. Special open enrollment periods are provided for employees who experience a change in family status or loss of coverage. If I elect not to add a newly acquired dependent within 31 days if the date of marriage, birth or adoption, I will not be able to enroll my eligible dependents until the next open enrollment period.

_____ _____

Employee Signature Date

HR Use Only
Received Date: _____ Approved By: _____ Effective Date: _____