

Refusal of group coverage



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Please PRINT clearly.

1 Identification

Contract number	Contract holder name	
Member's last name	First name	Date of birth (yyyy-mm-dd) — —

2 Declaration

I understand that I have a right to be covered under the Group contract offered by my employer. I confirm that I have chosen to refuse such coverage and I understand that as a result, my dependents and I are not entitled to make any claim for benefits under the Group contract.

I understand that if I apply for Group coverage at a later date, satisfactory proof of good health, at my own expense, will be required for myself and my dependents, if any.

I further understand that additional limitations in effect at that time under the Group contract may also apply.

Member's signature X	Date (yyyy-mm-dd) — —
Plan administrator's signature X	Date (yyyy-mm-dd) — —