

Medical and Dental Waiver of Coverage

SW Rodgers

For the plan year effective 01//01/2012 – 12/31//2012

Employee Name: _____
(Last) (First) (MI)

Social Security Number _____ - _____ - _____

I have been informed that I am eligible to apply for health coverage under SW Rodgers' Plan.

For the plan year effective 01 / 01 / 2012, I am waiving coverage for myself and eligible dependents in the following plan(s):

- Medical and Vision
- Dental

I am waiving coverage due to:

- My preference not to have coverage
- Coverage through my spouse's employer
- Other coverage:
 - Individual
 - COBRA
 - Medicare
 - Medicaid
 - TRICARE (formerly Champus)
 - Employer-Sponsored Group Plan

By signing below, I certify that I have been given an opportunity to apply for coverage for myself and my eligible dependents, if any. I am declining enrollment as indicated above. I understand that I am declining enrollment for myself or my eligible dependents (including my spouse) because of other health insurance or group health plan coverage. I may be able to enroll myself and my eligible dependents in this plan if I lose, or my eligible dependents lose, eligibility for that other coverage (or if the employer stops contributing towards my or my eligible dependent's other coverage).

I understand that I must request enrollment no more than 30 days after the date the other health plan coverage ends (or after the employer stops contributing towards my or my eligible dependent's other coverage). If I do not do so, I will not be able to enroll until my employer's next annual open enrollment period. I also understand that I may request enrollment within 60 days of losing eligibility for the Medicaid/CHIP program or that I may drop my current coverage upon eligibility for Medicaid/CHIP.

In addition, I understand that if I have a newly eligible dependent as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my eligible dependent(s). However, I must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

I understand that in order to request special enrollment or obtain more information, I should contact my group benefits administrator.

Employee's Signature

Date