



Legal Name: IGA Group Employee Benefit Trust
Version: IGA / Waiver / 0409

Adobe Reader Version 7 or later
is required to complete this form.
Download the FREE update at
www.adobe.com

COVERAGE WAIVER

Please complete this fillable form and click the Submit button. Then save it, print it, sign it and fax it to the number shown above.

SECTION I. EMPLOYER INFORMATION

Employer Name: Location (if more than one):

SECTION II. EMPLOYEE INFORMATION

Employee Social Security No. (No hyphens)

Form with fields for Last Name, First Name, MI, Address, City, State, Zip Code, Home Phone, Single/Married, Male/Female, Height, Weight, Date Of Birth, E-mail, Date Employed Full Time, Hours Worked Per Week, Occupation.

NOTE: Requested Effective Date of Coverage subject to employer waiting period and other limitations that may apply.

SECTION III. COVERAGE WAIVER

- 1. I waive coverage for: Self Only, Spouse Only, Dependents Only, Self and Spouse, Self and Dependents, Spouse and Dependents, Self, Spouse and Dependents

- 2. Reason for waiving coverage: Covered under spouse/parent's group plan, Covered under other policy, Not interested, have no other coverage

IF I HAVE WAIVED COVERAGE for myself and/or my dependents (including my spouse) because of other health insurance coverage, I may in the future be able to enroll myself and/or my dependents in this plan, provided that I request enrollment within 31 days after my other coverage ends because of involuntary loss of coverage (divorce, death, legal separation, termination of employment, reduction in number of hours of employment).

Applicant's Signature: Date: (mm/dd/yyyy)