WAIVER OF BENEFITS

RETURN THIS TOP PORTION IF YOU DO NOT WISH TO BE ENROLLED ON ONE OR MORE OF THE GROUP INSURANCE POLICIES

NAME: _____ ELIGIBILITY DATE: _____

If you do not wish to be enrolled on one or more of our group insurance policies, please indicate below; date, sign and return this form to:

Waco, Inc. - Attn: Vickie Corley or Bonnie Ballsrud
P.O. Box 829
Sandston, VA 23150

vcorley@wacoinc.net – Fax: (804) 226-3218
bballsrud@wacoinc.net – Fax: (804) 226-3218

☐ **I DO NOT** wish to be enrolled on Waco's Group Health Insurance Plan.

☐ **I DO NOT** wish to be enrolled on Waco's Group Life Insurance Plan.

☐ **I DO NOT** wish to be enrolled on Waco's Group Dental Insurance Plan.

Waiver of Participation

I acknowledge that I have been given the opportunity to become a participant in my employer's health and/or dental insurance plans. However, I have chosen not to participate at this time. By waiving participation, I realize I will not become eligible to participate until next plan anniversary date or if earlier, occurrence of a life event. This waiver will continue in effect until I notify the company in writing.

Required Statement for Health Insurance Waiver:
Reason for Waiver:
Spousal Coverage ____ Individual Policy ____ Other (specify reason)_____

You must state a valid reason for waiving coverage under the Health Insurance Plan.

_____ _____
Date Signature