

**Notification of Waiver Form (This form may be photocopied)**

**Please read, complete and sign this form if you are contributing toward the cost of coverage and are waiving coverage for any of the following insurance products: Life, Dental, STD and/or LTD.**

**Note:** Under contributory plans (where employees contribute towards the cost of coverage), eligible employees may elect to waive coverage. However, election to waive may not exclude that employee from the employer's participation requirements. Under non-contributory plans, all eligible employees must enroll. Eligible employees are defined on Page 1 of the Request for Participation and Enrollment form.

Employee's Name: \_\_\_\_\_

Name of Employer: \_\_\_\_\_ Policy Number(s): \_\_\_\_\_

Employee Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

**Please check the box for type(s) of insurance coverage you are waiving:**

☐ Life    ☐ Dental    ☐ STD    ☐ LTD

**If you are waiving dental coverage for yourself or your dependents, check all boxes that apply and provide information as applicable:**

☐ I have similar dental coverage under my spouse's plan

☐ My dependents have similar dental coverage under my spouse's plan

If either or both above boxes are checked, please provide the following information:

Name of spouse's insurance company: \_\_\_\_\_

Spouse's plan effective date: \_\_\_\_\_

☐ I do not have similar dental coverage under my spouse's plan, but I am waiving the employee dental coverage

☐ My dependents do not have similar dental coverage under my spouse's plan, but I am waiving the employee dental coverage

Please read and sign:

I, the undersigned, hereby affirm that I have reviewed the insurance plan(s) from Reliance Standard Life Insurance Company being offered by my employer. With my signature, I certify that I have decided to waive coverage as indicated above.

I understand that in the event I request to purchase such insurance at a later date: 1) I will be required to furnish evidence of insurability for myself (and any dependents, if such coverage is available) at my own expense; and 2) Reliance Standard Life Insurance Company will have the right to refuse my request. For dental coverage, I may be subject to reduced benefits.

Signature \_\_\_\_\_ Date \_\_\_\_\_