CHRISTIAN BROTHERS SERVICES

Employee Benefit Trust
1205 Windham Parkway
Romeoville, IL 60446
800.807.9460 / 630.378.3005 fax

Request for Waiver of Medical/Dental/ Vision (Optional Benefits)

When to use this form: An eligible employee still actively working at your location and is enrolled for Life, LTD, and optional benefits (medical/dental/vision), but now wants to waive (decline) his/her optional benefits. (Refer to "Your Employee Benefit" booklet for eligibility definition.)

Location Name:		Location #:	
Name:		Social Security #:	

I hereby certify that I have requested my employer to waive (decline) my optional benefits. I understand that if I waive (decline) at this time, future coverage may be deferred up to six months and may be subject to preexisting conditions limitation.

☐ Myself ☐ My Dependents ☐Medical ☐Dental ☐Vision

You must complete one of the following – Coverage is being waived because:

1. ☐ Employee enrolled on spouse's plan
2. ☐ Employee enrolled in employer provided HMO
3. ☐ Employee covered by another employer
4. ☐ Employee has own individual policy
5. ☐ Other, please explain:

Effective Date*:			
Signature of Employee:		Date:	
Administrator's Approval:			

*** This form must be sent within 31 days of the effective date.**