

**WAIVER  
OF  
GROUP HEALTH AND/OR DENTAL  
COVERAGE**

Employer Name \_\_\_\_\_

I hereby waive participation in the SCMA Members' Insurance Trust health and/or dental insurance coverage. I acknowledge that I have been offered the opportunity to participate in this plan and that I have been provided sufficient information about the plan to make an informed decision regarding participation.

I have chosen to decline this offer and waive coverage for:

**(Health)**  
\_\_\_\_\_ Myself (and eligible dependents if applicable)  
\_\_\_\_\_ My eligible dependents only

**(Dental)**  
\_\_\_\_\_ Myself (and eligible dependents if applicable)  
\_\_\_\_\_ My eligible dependents only

Reason for waiving coverage:

\_\_\_\_\_ I have other health coverage with \_\_\_\_\_  
(Name of Carrier)

\_\_\_\_\_ I have other dental coverage with \_\_\_\_\_  
(Name of Carrier)

\_\_\_\_\_ Spouse has other health coverage

\_\_\_\_\_ Spouse has other dental coverage

\_\_\_\_\_ Other (please explain) \_\_\_\_\_  
\_\_\_\_\_

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health and or dental insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents provided that you request enrollment within 30 days after the marriage, adoption or placement for adoption.

Employee Name (please print) \_\_\_\_\_

Employee Signature \_\_\_\_\_

Employee Social Security Number \_\_\_\_\_ Date \_\_\_\_\_