Waiver of Medical and/or Dental Coverage
Group Plans

For new Group Plans participants: If coverage is fully paid for by your employer, you must complete this form to waive (decline) medical and/or dental coverage for both you and your dependents under Group Plans.

For existing Group Plans participants: If you waive medical/dental coverage in which you and/or your dependents are already enrolled, one of the following applies:

- **For employer-paid coverage (employee-only coverage or employee, dependent or family coverage):** Coverage will terminate the date this form is received or a future date if requested. Coverage may be terminated retroactively up to 31 days from receipt of the termination request.
- **For employee-paid coverage (employee-only coverage or employee, dependent or family coverage):** Coverage will end on the last day of the month through which the employee has paid for coverage (paid-through date). **Please provide the paid-through date in the section below**.

CERTIFICATION AND WAIVER Reset Form

Employer: Overseas Management Employer number: 74396

Employee name: _____ Social Security number (last four digits): _____

This is to certify that I have been given the opportunity to apply for or continue medical and/or dental coverage provided to me and/or my dependents at no cost to me by my employer. **My employer has not provided or indicated that it will provide any financial or other incentive whose primary purpose is to cause me to waive coverage.** I understand that my dependents are not eligible for coverage if I waive coverage for myself.

I waive medical coverage for:

- ☐ Myself
- ☐ Myself and all eligible dependents
- ☐ All eligible dependents
- ☐ Only these dependents:

Reason for waiving:

- ☐ Other group medical coverage
- ☐ Other individual medical coverage
- ☐ Other (explain): _____

Name: _____ Social Security number (last four digits): _____

Name: _____ Social Security number (last four digits): _____

Name: _____ Social Security number (last four digits): _____

I waive dental coverage for:

- ☐ Myself
- ☐ Myself and all eligible dependents
- ☐ All eligible dependents
- ☐ Only these dependents:

Reason for waiving:

- ☐ Other group dental coverage
- ☐ Other individual dental coverage
- ☐ Other (explain): _____

Name: _____ Social Security number (last four digits): _____

Name: _____ Social Security number (last four digits): _____

Name: _____ Social Security number (last four digits): _____

Effective date for waiver of coverage: _____/_____/_____ (Coverage will terminate on the date this form is received if a future date is not indicated.)

I understand that if I ask for coverage later, the terms of the plans will control my ability to get coverage. I also understand that waiting periods and other limitations may apply.

Employee signature: _____ Date: _____/_____/_____

Employer representative: _____ Date: _____/_____/_____

Special enrollees for medical coverage: Under federal law, if you decline enrollment for medical coverage for yourself or your dependents because of other medical (not dental) coverage, you may in the future be able to enroll yourself or your dependents as special enrollees in Group Plans. Also, if you acquire a new dependent due to marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents as special enrollees. To enroll as a special enrollee for medical coverage, you must request enrollment within 60 days after your other coverage ends or within 60 days after the marriage, birth, adoption or placement for adoption. These rules do not apply for dental coverage.

Note: Please see the plan booklets for information about waiting periods and other limitations for special enrollees.

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