PREMIER ACCESS
Dental and Vision

INDIVIDUAL WAIVER STATEMENT

(Use this form for employees electing to waive coverage for themselves and/or their dependents.)

Current Group Number:

Waiver Statement:

I have been given the opportunity to enroll in the group dental plan my Employer has obtained from Premier* and, after consideration, have decided to waive coverage for:

- ❑ Myself and all Dependents
- ❑ My Spouse
- ❑ My Dependents (Spouse and Child(ren))
- ❑ My Dependent Child(ren)

Employee Information:

Social Security Number: _____

Last Name: _____ First Name: _____ MI: _____

Street Address: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

E-mail Address: _____

Employer (Company) Name: _____

Reason for Waiver:

❑ I am declining coverage because I am covered under another dental plan not affiliated with my current Employer. This coverage is provided through:

- ❑ My Spouse's Employer Plan (Employer's Name): _____
- ❑ Military ❑ Individual Policy ❑ Medicare/Medicaid ❑ Other: _____
- Insurance Carrier's Name: _____

❑ Coverage is being declined for my Spouse because he/she is covered under another dental plan.

- Spouse's Name: _____
- Insurance Carrier's Name: _____

❑ Coverage is being declined for my Child(ren) because he/she is covered under another dental plan.

- Child(ren)'s Name(s): _____
- Insurance Carrier's Name: _____

❑ Coverage is being declined for my Spouse and/or Child(ren). They are not covered under another dental plan.

- List Name(s): _____

I understand that if I later decide to apply for coverage for myself or any dependents for which I am waiving coverage at this time, Premier may consider me a late enrollee and may impose a Benefit Waiting Period. I also understand that at the time of my subsequent application for coverage, I will have to comply with the applicable group dental Policy requirements for eligibility and enrollment.

You will not be considered a late enrollee if one or more of the following applies:

1. *You or Your waiving Dependents were covered under another dental plan at the time of waiver, you are no longer covered under the other dental plan for one of the reasons stated below and you request enrollment in Premier within 30 days after termination of coverage or Employer contribution under the other dental plan.*
   a. *Termination of employment;*
   b. *Change in employment status;*
   c. *Termination of the other plan's coverage;*
   d. *Cessation of an employer's premium contribution toward an employee's or dependent's coverage; or*
   e. *Death of or divorce from the individual through which the waiving individual was covered as a Dependent.*
2. *A court orders coverage be provided for a spouse or child of an insured Employee and request for enrollment under Premier is made within 30 days of the issuance of the court order.*
3. *You are employed by an Employer that offers multiple dental plans and You elect a different plan during an open enrollment period.*

Employee Signature: _____ ***Date:*** _____

_____ _____

* *All references to "Premier" herein refer to Premier Access Insurance Company*