



EMPLOYEE WAIVER OF GROUP INSURANCE COVERAGE

Employer Name:	
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GBS Account # (existing accounts only):	
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Employee Name:	
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Employee Home Address:	

Employee Social Security Number:	
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I hereby certify that I have been given an opportunity to apply for group insurance coverage. I understand fully the benefits available to me under the plan. I decline to participate and hereby waive all benefits of the plan for the following reasons:

- Not Interested
- Covered by Spouse's insurance program
- Covered by other insurance
- Refuse for religious reasons

I understand that if I desire to apply for this insurance at a later date, I may be medically underwritten or coverage may be delayed to the next open enrollment period.

Waiver applies to: ___ Medical ___ Dental ___ Life Insurance
 ___ Short Term Disability ___ Long Term Disability

Employee Signature

Date