WAIVER

Admin. Use Only
EWC
DWC
Case # __________

(may be photocopied or duplicated)

WAIVER OF GROUP HEALTH COVERAGE UNDER
THE WELLNESS HORIZONS® GROUP HEALTH PLANS

AFTER due consideration, it is my determination:

- ❑ Not to apply for coverage for myself and my dependents in the Group Health Plan.
- ❑ Not to apply for coverage for my dependents in the Group Health Plan.

Please answer the following:

1. I and/or my dependents are covered under another employer sponsored Health Benefit Plan (if your Spouse is covered under an employer sponsored plan, please provide the name of the employer)..❑ YES ❑ NO

   Name of employer ____

   I and/or my dependents are covered under an individual health plan..❑ YES ❑ NO

   Name of insurance carrier above ____

   Policy or Certificate Number____

   Telephone Number of Company or Claims Department ____

2. I opt not to apply for coverage for myself and/or my dependents in the Group Health Plan due to reasons other than having any existing coverage as listed above. I understand that I have the right to apply for coverage at this time and am voluntarily declining coverage. ....❑ YES ❑ NO

If you are declining coverage for yourself or your dependents (including your spouse) because of other health 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 31 days after the marriage, birth, adoption or placement for adoption.

I understand that not applying for coverage due to reasons other than having qualifying existing coverage has important consequences:

a. My dependents and I may be excluded from coverage as described in the Late Applicant Eligibility provisions set forth in the Certificate; or

b. The effective date of coverage for myself and my dependents may be delayed, as described in the Late Applicant Eligibility provision in the Certificate; or

c. The period during which pre-existing conditions will not be covered may be extended for myself and my dependents, as described in the Late Applicant Eligibility and Pre-Existing Conditions Limitations provisions in the Certificate.

As a result, I waive all claim benefits payable thereunder for myself and/or my dependents.

I understand the above information may be verified in order to determine whether the participation requirements for this group application meets underwriting standards.

Name of Employee: ____

Name of Employer: ____

Signature of Employee:______________________________________ Date ________________

Social Security No: ______________________________________

ALLIED NATIONAL
UNDERWRITING DEPARTMENT
P. O. Box 29187
Shawnee Mission, KS 66201-9187

Electronic copies of this application submitted via facsimile, email, or other electronic means shall be deemed an original.