



**PREMIUM ONLY PLAN  
WAIVER FORM**

Return completed form to your employer

<b>Employer Information</b>	
Employer Number:	_____
Employer Name:	_____
Plan Year:	_____ through: _____
<b>Employee Information</b>	
Employee Social Security Number:	_____
Employee Name:	_____
<b>Waiver Signature</b>	
<p><b>I elect NOT to participate in my employer's Premium Only Plan. The Premium Only Plan is one component of a cafeteria plan that allows employees to use pretax dollars to pay for their portion of the cost of employer sponsored group insurance premiums, such as accidental and health plan coverage (major medical coverage), dental, vision, and/or disability (STD/LTD). I understand that my portion of group insurance coverage premiums will be paid with after-tax dollars.</b></p>	
_____	_____
Employee Signature	Date

**NOTE: IF YOU DO NOT RETURN THIS FORM TO YOUR EMPLOYER PRIOR TO THE EFFECTIVE DATE OF THE PLAN, YOU WILL BE AUTOMATICALLY ENROLLED IN YOUR EMPLOYER'S PREMIUM ONLY PLAN.**

Questions? Call Member Services at or 1-800-859-2144.