

WAIVER OF COVERAGE FORM

DECLINING GROUP COVERAGE



1133 S.W. Topeka Boulevard, Topeka, KS 66629-0001
Phone in Topeka (785)273-9804, in Kansas (800)530-5989
Fax (785)290-0727 website: www.advanceinsurance.com

I DO NOT WANT TO ENROLL IN:

(Note: unless you are paying some (or all) of the premium for the benefit named below, declining coverage is not an option available to you.)

- | | | | | | |
|-----------------------|--------------------------|---------------|--------------------------|--|--------------------------|
| Basic Life and AD&D | <input type="checkbox"/> | Optional Life | <input type="checkbox"/> | Voluntary Life (and AD&D, if applicable) | <input type="checkbox"/> |
| Dependent Life | <input type="checkbox"/> | | | Voluntary Short Term Disability | <input type="checkbox"/> |
| Short Term Disability | <input type="checkbox"/> | | | Voluntary Long Term Disability | <input type="checkbox"/> |
| Long Term Disability | <input type="checkbox"/> | | | Voluntary AD&D | <input type="checkbox"/> |

The group insurance program has been offered to me and, after seriously considering its benefits, I have decided not to enroll.
Reason: _____

I understand that satisfactory Evidence of Insurability will be required if I, my spouse, or children do not enroll when first eligible and choose to participate in the insurance program at some future date. I understand I will be responsible for payment of all expenses necessary to determine a Late Enrollee's insurability, including but not limited to, exams or obtaining medical records for myself (my spouse, or children); and, that the late enrollee may be declined for the insurance.

Employee name (please print) _____ Social Security # _____
Employee sign here *X* _____ Date signed _____
Employer name _____ Location _____
Employer sign here *X* _____ Group # _____