

WAIVER (REFUSAL OF COVERAGE)

I acknowledge that I have been given the opportunity to apply for group coverage available to me and my dependents through my employer. I proclaim that I was not pressured or forced by my employer, the writing agent into waiving (declining coverage). If I have waived any coverage offered to me or my dependents, my signature is evidence of this action.

I hereby waive coverage for (check all that apply)

- Myself
- My Spouse
- My dependent child(ren)

I decline to apply for group coverage because of:

- Spousal Coverage
- Medicare Supplement
- Individual Coverage
- Coverage under another carrier's plan provided by my employer
- Other:

Please sign below **ONLY** if you are declining coverage for yourself and/or dependent(s).

Employee Signature

Date (mm/dd/yy)

EMPLOYEE STATEMENT AND SIGNATURE

I HEREBY: Request enrollment in the self-funded Group Health Plan (Plan) established and maintained by my employer (Employer) for its eligible employees and their eligible dependents; Represent that I am eligible employee of the Employer; Represent that my statements and answers to the questions in this enrollment form are true and complete to the best of my knowledge and belief; and Authorize the Employer to deduct any required Plan contribution from my earnings.

I FURTHER ACKNOWLEDGE AND UNDERSTAND: This is not an insured benefit plan; All Plan benefits are self-funded (self-insured) by the Employer; The Employer is solely responsible for benefit payments; Coverage is not effective until the Plan approves this enrollment form; Plan benefits are available only if a person is covered under, and all required contributions for such coverage have

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, if you request enrollment within 31 days of ineligibility or termination of employer contributions; If you decline enrollment for any dependent (including your spouse) because of coverage under Medicaid or a State child health plan, and that dependent's coverage is subsequently terminated due to ineligibility, he/she may be able to enroll without delay or penalty, if you request enrollment within 60 days of termination of coverage; If you decline enrollment for any dependent (including spouse) and that dependent subsequently becomes eligible for a premium assistance subsidy from Medicaid or a State child health plan, he/she may be able to enroll without delay or penalty, if you request enrollment within 60 days of eligibility for the subsidy. To request special enrollment contact the Employer or The Loomis Company Concierge Team at 866.218.6009.

PERSONAL INFORMATION NOTICE: As required by law, this notice is intended to inform you that 1) Personal information may be collected from third parties; 2) Such information as well as other personal or privileged information collected by the health plan or its legal representative may be in certain instances, as prescribed by law, disclosed to other third parties without your prior authorization; 3) You have the right to access and correct the collected information; 4) Your right to access does not include any information which relates to and is collected in connection with, or in reasonable anticipation of, a claim or civil or criminal proceeding; 5) We will provide a more detailed notice of information practices upon request.

Signature of Employee

Date (mm/dd/yy)

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