GROUP POLICY NUMBER:	**DIVISION:**	**EMPLOYEE ID NUMBER:**
EMPLOYER NAME:	**EMPLOYEE NAME:**	

I, having been given the opportunity to participate in the Group Insurance Plan offered by my employer under the above group policy number, **do hereby refuse to participate** in the following: (select which benefit(s) apply to your refusal to participate)

- All Group Insurance Benefits.
- Medical and Dental Benefits.
- All Group Dependent Benefits.

It is understood that, if I request any refused benefit(s) at a later date, satisfactory evidence of insurability, at my own expense, may be required. Also, any refused benefit may have restrictions applied for a specified period of time.

DATE: ______________________ **EMPLOYEE SIGNATURE:** ________________________________

DATE:_______________________ **EMPLOYER SIGNATURE:**_______________________________

EMPLOYER NAME:____________________________________

EMPLOYER POSITION:_________________________________