

# WAIVER OF HEALTH AND/OR DENTAL CARE

- You must complete and sign this form if you choose to waive health and dental benefits under your group plan
- You may waive health and dental coverage for yourself and/or your dependents ONLY if you have comparable coverage through a spouse, an individual plan, or other group insurance plans
- If comparable coverage terminates or reduces at a later date, you may apply for health and dental coverage within 31 days of that coverage terminating/reducing without requirement of Evidence of Insurability

Group Name & Division Name/Number

Employee's Name (Last/First/Middle)

Waiver of Extended Health Care Benefits  
I do NOT want Extended Health Care for *(check one only)*

Myself and my dependent(s)

My dependent(s)

Waiver of Dental Care Benefits  
I do NOT want Dental Care for *(check one only)*

Myself and my dependent(s)

My dependent(s)

For Quebec residents age 65 or over

I am participating in the RAMQ drug plan provided by the Quebec government

I am NOT participating in the RAMQ drug plan provided by the Quebec government

**I hereby waive health and/or dental benefits, as indicated above, under this group insurance plan because I have comparable coverage elsewhere. I understand that proof of insurability (i.e., medical evidence) may be required if I wish to apply for these benefits at a later date. I understand that I may be denied coverage at that time.**

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_, 20  
Date Signed

\_\_\_\_\_  
Employer's Signature

\_\_\_\_\_, 20  
Date Signed

Employee ID number

Name