Benefits Waiver and Decline Form

Employee Information

Full Name

Employee ID

Department

Date

Benefits Waived / Declined

- [ ] Medical Insurance
- [ ] Dental Insurance
- [ ] Vision Insurance
- [ ] Life Insurance
- [ ] Other

If Other, please specify:

Reason for Waiving / Declining

Employee Acknowledgment

By signing below, I acknowledge that I have been offered the above benefits by my employer and that I am

voluntarily waiving/declining the indicated coverages.

Employee Signature

Date