DIOCESE OF LA CROSSE LAY GROUP BENEFIT PLAN

Waiver of Coverages

Parish/Institution _____ # _____ City _____

Last Name _____ First Name _____ MI _____ Date of Birth _____ Social Security No. _____

Street Address _____ Home Phone Number _____

City _____ State _____ Zip _____ Personal Email _____

WAIVER OF BENEFITS (Must sign below if waiving coverage)

I, the undersigned, an employee of the above-named policy holder, hereby certify that I have been given an opportunity to apply for group insurance benefits as offered by my employer and after careful consideration, I hereby waive my right to:

____ Medical Plan ____ Dental Plan ____ Basic Group Life Insurance

____ Voluntary Life Insurance ____ Voluntary Long-Term Disability Insurance ____ Voluntary Vision Plan

Reason for waiving coverage(s): _____

_____ _____

Signature of Employee (required) **Date**

Completed Form is to be retained with the Employer as part of the Employee's file. It is not ncessary to submit this form to insurance company or St. Ambrose Financial Services, Inc.

Rev. 11/2021