

**Please send forms to:**

Concord Management Resources  
P.O. Box 5487  
Somerset, NJ 08875  
Phone: 833-MEWANOW (833-639-2669)  
Fax: 833-MEWAFAX (833-639-2329)  
Email: mewaenrollment@concordmgt.com

**HEALTH BENEFIT WAIVER**

This benefit waiver is available to employees who are regularly scheduled to work a minimum of 24 hours or more every week. Upon renewal of the Group Health Plan, employees may elect to continue to waive out or enroll in the benefit program during the open enrollment period, or at any time upon a qualifying event as defined in the Plan's Summary Plan Description.

**WAIVER**

I, \_\_\_\_\_ voluntarily agree to waive coverage under the health benefits offered by \_\_\_\_\_. I understand the above explanation of my rights to waive benefits or enroll in the benefit program offered.

I realize that I can enroll in the group health plan being offered at this time, but have chosen not to participate. I also understand that hereafter I may apply for coverage only during the open enrollment period of the Group Health Plan or if a qualifying event occurs as defined in the Plan's Summary Plan Description.

Choose one of the below options that apply:

\_\_\_\_\_ I knowingly do not have any type of health (medical, vision & prescription drug) benefits and do not wish to participate in the Group Health Plan being offered.

\_\_\_\_\_ I certify that I am covered by the following health insurance plan:

Name of Health Insurance Plan: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Company or Group Sponsor: \_\_\_\_\_

(Please attach copy of Insurance Card)

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Employer Signature

\_\_\_\_\_  
Date

**Account #:** \_\_\_\_\_  
To be completed by Plan Administrator