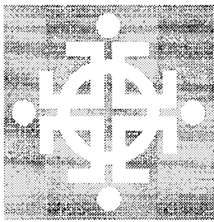

BETHANY BENEFIT SERVICE

Providing church-worker benefit billing for the churches and institutions of the Evangelical Covenant Church.

Waiver of Health Insurance

I am aware of the fact that Bethany Benefit Service has extended the election of Health, Vision, Dental and Prescription insurance to me. I understand that if I waive coverage for myself and/or my eligible dependents at this time and wish to apply at a later date, an *Evidence of Good* Health or a *Certificate of Credible Coverage* will be required. I acknowledge that it is my choice to waive health insurance coverage at this time.

☐ I decline coverage for myself for the following reason:

- ☐ I am covered by another health plan.
  - Primary Cardholder:______________________________
  - Name of Employer:______________________________
  - Name of Insurance Company:______________________
- ☐ Other reason:______________________________

☐ I decline coverage for my eligible dependents for the following reason:

- ☐ They are covered by another health plan.
  - Primary Cardholder:______________________________
  - Name of Employer:______________________________
  - Name of Insurance Company:______________________
- ☐ Other reason:______________________________

I, ____________________ (print first and last name), hereby waive health insurance coverage, effective on __/__/____.

Signature:______________________________ Date:__________________

IMPORTANT: Return this form to Bethany Benefit Service at:
Bethany Benefit Service
Attn: Christina Koning
P.O. Box 25263
Chicago, IL 60625-0263