PARTIAL WAIVER

Benefits by Design

Name of Employer:

To use this form you must already be insured under your employer's plan.
For a new enrollment complete a Group Insurance Enrollment form.

Employee - Complete for partial waiver due to coverage under another group plan		
Employee Last Name:	First Name:	Initial:
I elect to waive the benefits checked below because comparable coverage is provided to me an/or my dependents under another group plan: (specific plan details below)		
For myself and my dependents... ☐ Extended Health Care ☐ Dental Care ☐ Health Care Spending Account **OR** For my dependents only... ☐ Extended Health Care ☐ Dental Care ☐ Health Care Spending Account		
Name of Other Plan's Employer/Policyholder:		Is this your spouse's group plan? ☐Yes ☐No (if no, provide details) _____ _____
Name of Insurance Company:		
Group Number:	Identity Number:	
Effective Date: _____		