WAIVER OF COVERAGE FORM

WAIVING COVERAGE - UNDERSTANDING THE CHOICE

With respect to Waiver of any coverage under the Pacific First Group Plan, I acknowledge that I have been offered the benefits of my employer's Group Plan with Pacific First and the benefits provided by this Plan have been fully explained to me. I further acknowledge that I am forfeiting (as indicated below) all my rights and privileges in respect to such benefits. I understand that if I apply for waived coverage in the future, I may be requested to provide evidence of eligibility at my own expense.

Waiver of Extended Health and/or Dental Coverage (Spousal Opt Out)

Employer Name: _____ Plan No.: _____

Employee Name: _____
(please print)

I and/or my dependents have coverage through my spouse's group insurance plan and I/we do not wish to coordinate benefits through both plans, therefore I/we wish to waive the following coverage's:

Extended Health coverage for me and my dependents _____

Extended Health coverage for my dependents only _____

Dental coverage for me and my dependents _____

Dental coverage for my dependents only _____

Spouses Insurance Company: _____ Plan #: _____

Note: Family coverage will be provided until spouse's insurance carrier information is provided.

Employee Signature: _____

Date: _____
yyyy/mm/dd

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