CENTRAL RESERVE LIFE INSURANCE COMPANY
17800 Royalton Road • Cleveland, OH 44136-5197 • 440-572-2400
www.centralreserve.com

NON-PARTICIPATING EMPLOYEE WAIVER

IMPORTANT NOTICE: THIS IS NOT AN APPLICATION FOR HEALTH INSURANCE

EMPLOYEE NAME	DATE OF BIRTH			HEIGHT		WT.
	MO.	DAY	YEAR	FT.	IN.	LBS.

EMPLOYER NAME	POLICY #	DATE OF EMPLOYMENT	OCCUPATION

In order for Central Reserve Life Insurance Company (CRL) to consider providing health insurance for the eligible employees applying for coverage with the above-named Employer, this Non-participating Employee Waiver (Waiver) ***must be completed*** *by all full-time employees unless they are applying for coverage with the initial group or are accounted for by a legitimate class exclusion.*

A. **Please indicate the reason for declining to apply for health insurance coverage (waiving coverage):**

1. ☐ Covered under spouse's insurance
2. ☐ Covered under an HMO – (Not more than 50% of the group can be covered under an HMO)
3. ☐ Covered through Medicaid or similar government funded program
4. ☐ Covered through a state sponsored high risk pool
5. ☐ Disability – Date anticipating returning to work full time: ____________
6. ☐ Temporary job suspension or on leave of absence – Date anticipated returning to work full time: ____________
7. ☐ Covered under continuation (e.g., COBRA) through another insurance carrier or spouse – Date of termination: ____________
8. ☐ Other (Subject to Home Office Approval): ____________

B. **Health History:** In order to assist CRL in evaluating its potential risk of providing health insurance coverage for the above-named employer, the following questions must be answered in full, with details provided.

1. During the past two (2) years, have you or any of your dependents been hospitalized or operated on for any reason? .... ☐ Yes ☐ No
2. Are you or any of your dependents currently under a doctor's care, taking medication, or contemplating medical or surgical treatment in the future? .... ☐ Yes ☐ No

If the answer is "Yes" to any of the above, provide complete details below (add extra sheets if more space is needed):

Certification of Waiving Employee : I hereby certify that (i) I have been given the opportunity to participate in the Group Insurance plan provided through my employer; (ii) the benefits of this plan have been thoroughly explained to me; (iii) I decline to participate; and (iv) if I desire to apply for insurance at a later date, I may be considered a late enrollee and, as such, coverage for a Preexisting Illness may be delayed up to a maximum of eighteen (18) months. (In Texas, late enrollees may apply through open enrollment and be subject to a twelve (12) month maximum Preexisting Illness exclusion.)

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan without being considered a late enrollee, provided that you request enrollment within 31 days after losing your other coverage. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents (without being considered late enrollees), provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Furthermore, I certify that all of the above information provided by me in completing this form is accurate, complete and true to the best of my knowledge and that I was not induced or pressured by the small employer, agent, or health carrier, into declining coverage, but elected on my own accord to decline such coverage. In addition, I have not disclosed to the agent any health information not provided on this form. I understand that if I apply for coverage at a later date, this waiver will become part of my application.

____ ______________________________

Signature of Employee Date