Benefit Declination Form

First Name	Last Name	Marital Status

Email	Phone

Address	City	State	ZIP

Date of Birth	SSN	Hire Date	Tobacco Use (Yes / No)

I Acknowledge.	By selecting the box on the left, you verify that you have reviewed and understand the coverages made available to you by your employer and would like to decline any coverage at this time.
☐	

Authorization and Request for Coverage

I hereby enroll or decline as indicated above in the benefits for which I am eligible.

I acknowledge and understand that the cost for any and all benefits I enroll in will be deducted from my payroll.

Signature