**Submit to:**

Benefit Services
PO Box 950
Forest Hill, MD 21050

**p 866.902.6227**
**f 866.903.6227**

Legal Name: Custom Rail Employer Welfare Trust Fund
Version: CREW / Waiver / 0409

**Adobe Reader Version 7 or later is required to complete this form. Download the FREE update at www.adobe.com**

# COVERAGE WAIVER

**Please complete this fillable form and click the Submit button. Then save it, print it, sign it and fax it to the number shown above.**

## SECTION I. EMPLOYER INFORMATION

Employer Name: ______________________ Location (if more than one): ______________________

## SECTION II. EMPLOYEE INFORMATION

Employee Social Security No. ______________________ (No hyphens)

| Last Name: | | First Name: | | MI: |
|---|---|---|---|---|
| Address: | | City: | State: | Zip Code: |
| Home Phone: (No hyphens) | Single Married | Male Female | Height: | Weight: |
| Date Of Birth: (mm/dd/yyyy) | | E-mail: | | |
| Date Employed Full Time: (mm/dd/yyyy) | | Hours Worked Per Week: | | Occupation: |

**NOTE:** Requested Effective Date of Coverage subject to employer waiting period and other limitations that may apply.

## SECTION III. COVERAGE WAIVER

1. **I waive coverage for:** Self Only   Spouse Only   Dependents Only   Self and Spouse   Self and Dependents   Spouse and Dependents   Self, Spouse and Dependents

2. **Reason for waiving coverage:** Covered under spouse/parent's group plan   Covered under other policy   Not interested, have no other coverage

**IF I HAVE WAIVED COVERAGE** for myself and/or my dependents (including my spouse) because of other health insurance coverage, I may in the future be able to enroll myself and/or my dependents in this plan, provided that I request enrollment within 31 days after my other coverage ends because of involuntary loss of coverage (divorce, death, legal separation, termination of employment, reduction in number of hours of employment). In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents, provided that I request enrollment within 31 days after the date of the event. I further understand that if this form is submitted after the enrollment period, and my employer has elected to cover late enrollees, a longer limitation may apply to pre-existing conditions disclosed herein, even though I may be accepted for coverage.

Applicant's Signature: ______________________ Date: ______________ *(mm/dd/yyyy)*