USHL SafeGuard
US Health and Life
US HEALTH AND LIFE INSURANCE COMPANY

Employee Waiver Form

8220 Irving Road • Sterling Heights, MI 48312 • 844-828-5968 • www.ushealthandlife.com

General Information

Group (Employer) Name_____

Date of Hire_____

First Name _____ MI_____ Last _____

Address_____ City_____ State_____ Zip_____

Date of Birth _____ Social Security Number_____

☐ Male ☐ Female

Daytime Phone Number_____ Email Address_____

Life Insurance Beneficiary Name_____ Relationship_____

This form is required for all eligible employees and dependents who are not enrolling with US Health and Life at the time of initial enrollment and/or the group's open enrollment period.

I decline to enroll for Medical (check all that apply): ☐ myself ☐ spouse ☐ children

Dependent Information

Coverage Selection: Dental ☐ Yes ☐ No Dependent Life ☐ Yes ☐ No

Please complete the following for each enrolling individual for dependent life and/or dental if elected by group.

First Name	MI	Last Name	Relationship	Date of Birth	Sex	Social Security No.

Waiver

I waive the right to enroll with US Health and Life as offered to me by my employer for the following reason (please check one):

☐ I have other coverage through my spouse ☐ I have other coverage through Medicare

☐ I have individual coverage ☐ I have no other coverage but choose not to enroll in my employer's plan

☐ Other (explain) _____

I understand that if I and/or my dependents, if any, waive coverage and desire to participate in the plan at a later date, coverage will be subject to treatment as a late enrollee and I may only apply at the next open enrollment period. I further understand that if I decline enrollment for myself or my dependents (including my spouse) because of other health coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 30 days after such other health coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependent, provided that I request enrollment within 30 days after such marriage, birth, adoption or placement for adoption.

Employee Signature_____ Date_____

For Office Use Only

EFF DATE _____ MED _____ CLASS _____

DIVISION # _____ DEN _____ LIFE _____