WINDSOR
HEALTHCARE RECRUITMENT

Group Benefits Waiver Form

Name:	Title/Position:
Clinical Role:	SSN:

Please check all that apply:

	I waive my employer's group Health insurance coverage for myself and my dependents (if any).
	I waive my employer's group Dental insurance coverage for myself and my dependents (if any).
	I waive my employer's group Vision insurance coverage for myself and my dependents (if any).

Please review and then sign below:

- I confirm that I have been given full opportunity to apply for coverage for myself and my eligible dependents.
- I confirm that I have alternative coverage in place if refusing this cover.
- I acknowledge that my dependents and I may not be eligible to enroll for benefits until the next open enrollment period.
- I acknowledge that if I fail to submit properly completed enrollment forms prior to my first day of work, I shall not be eligible to cover until the required enrollment forms are submitted.

Signature:	Date: