Mission Yogurt Inc.

HEALTH INSURANCE WAIVER

LAST NAME: FIRST NAME: M:

HIRE DATE: STORE: CURRENT STATUS:

FULL TIME ☐ *PART TIME* ☐

I acknowledge that I have been offered the opportunity to purchase health coverage from Mission Yogurt, Inc. provided by Cigna. I decline enrollment at this time because:

☐ I am covered by a parent's coverage

Carrier Name and Member ID_____

☐ I am covered by a spouse's/domestic partner's group coverage

Carrier Name and Member ID_____

☐ I am enrolled an another Insurance Carrier Plan

Carrier Name and Member ID_____

☐ I am covered by Medicare and/or Medicaid

I D Number _____

☐ Other_____

Notification to Enroll

☐ I acknowledge that a Human Resources Representative will contact me before the 1st of the month following 60 days of employment to speak about coverage.

Rights to Coverage

If you chose to decline coverage for yourself or dependents (including your spouse) because of other health care coverage, you may enroll yourself or your dependents in this plan prior to the next open enrollment period (under certain circumstances, please contact HR for a full description of circumstances). To do this, you must have involuntarily lost your other coverage and we must receive your enrollment application within 10 days after your other coverage ended. Additionally, if you have new dependents as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and dependent, provided we receive your completed enrollment application within 30 days after the marriage. birth, adoption, or placement for adoption.

Employee Signature: _____ Date: _____