# Crewpackwings

# WAIVER OF MEDICAL BENEFITS

## CREWPACKWINGS WAIVER OF MEDICAL BENEFITS

www.crewpackwings.com
info@crewpackwigs.com

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# WAIVER OF MEDICAL BENEFITS

In order to waive medical benefits under the  Health & Welfare Plan (the Plan), I understand that I can only do so in an Open Enrollment Period, unless I am a new hire.

Please note that if you are neither a new hire nor an enrollee in a current Open Enrollment Period, then you are not eligible to waive coverage at this time. This waiver includes your spouse/partner and each of your dependents you are electing not to enroll for health insurance at this time.

I._____

, hereby state that I do not want and hereby waive,

group health insurance coverage that I have received and reviewed for the plan year 2023 for myself, my spouse/partner and my dependent child(ren).

If declining coverage due to other employer-sponsored group coverage, for each family member, please list the name and phone number of the insurance company (or employer if covered through a self-funded plan), as well as the name and SSN of the Primary Insured, and the Policy Number. If a family member currently has no coverage, please write, "no coverage" next to the family member's

NAME OF COVERED FAMILY MEMBERS

_____

_____
_____
_____
_____
_____
_____

INSURANCE CAMPANY NAME (if known) or Employer (if self-funded)

_____-
_____-
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_____-
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_____

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_____-
_____-
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_____-

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Primary insured and SSN

_____
_____
_____
_____
_____
_____
_____

POLICY NUMBER (if you know)

_____-
_____-
_____-
_____-
_____-

I understand that this policy must be:
Through another current employer; or
Through a spouse's employer; or
Through a previous employer's retiree or Other plan.
I understand that I must provide evidence of current participation in another employer-sponsored group medical plan in order to waive medical benefits under the present Plan. I understand that "evidence" in this context shall mean a photocopy of both sides of the ID card issued to me as a participant in the other plan.
I understand that Medicare, TRICARE (Champs) and an entitlement to VA services do not qualify as "another employer-sponsored group medical plan" and, therefore, do not provide a basis for waiving medical benefits under the Plan.
I understand that failure to provide evidence to CREWPACKWINGS within 30 days of completing, signing, and submitting this waiver will nullify this election to waive and will result in my automatic enrollment in the medical benefits under the present Plan.
I understand that my election to waive medical coverage under the Plan may result in an allocation of Plan assets to fund another benefit for me in lieu of the Plan's medical. coverage. I understand that these funds will not be released for this purpose until CREWPACKWINGS

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has received this completed and signed Waiver of Medical Benefits and has validated the evidence submitted in support of my waiver election.

I understand that my election to waive medical benefits under the Plan does not affect my participation in other benefits under the Plan that are mandatory.

Understanding all of the foregoing, I certify that I have been given the opportunity to apply for group health insurance coverage and decline to enroll as indicated above, on behalf of myself, my spouse/partner, and my dependent child(ren). I understand that by signing this waiver, I, my spouse/partner, and my dependent child(ren) forfeit the right to insurance at this time. I was not pressured, forced, or unfairly induced by my employer, the agent, or Companion Life Insurance Company into waiving or declining group health insurance coverage. If in the future I apply for coverage, I, my spouse/partner, or any of my dependent child(ren) may be treated as a late enrollee and subject to postponement of insurance coverage until I am eligible to apply during the company's Open Enrollment period.

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I also understand that if I am declining enrollment for myself, my spouse/partner, or my dependent child(ren) because of other health coverage, I may, in the future, be able to enroll myself, my spouse/partner, or my dependent child(ren) in this plan, as required by law, provided that I request enrollment within 30 days after my other health insurance coverage ends or a qualifying event occurs. If I do not request enrollment within 30 days of the above events, I understand that I may not be able to enroll for coverage until the company's Open Enrollment period. I understand that I can obtain information related to my enrollment eligibility from my employer or the insurance company.

I hereby release CREWPACKWINGS, its agents, and the Plan from all liabilities which may result from the implementation of this waiver.

DATE

_____-

_____-

Signature

_____

Social Security number

_____

Date of birth

_____

Print Name