# Waiver of Enrollment

Declining Group Life or Disability Insurance

A copy of this completed Waiver of Enrollment must be submitted to Advance Insurance Company of Kansas (AICK).
1133 SW Topeka Blvd., Topeka, KS 66629-0001 • Fax: (785) 290-0727 • Toll Free: (800) 530-5989

## Section 1 – Important Notice

Whether or not you participate in your employer's health insurance plan does not affect your right to participate in the group life or disability benefits as long as the job you perform is included in a covered class of employees, you meet the company-imposed waiting period requirement, and you continue to actively work the number of hours each week that is required for your group's life and/or disability plan(s).

## Section 2 – Employee Information

First Name ________ MI ____ Social Security Number _____-_____-_______ Date of Birth _____ /_____ /_______

Last Name ________ Suffix ____ Employer Name ________

Mailing Address (if different from residential address) ________ Employee's Date of Hire _____ /_____ /_______

City ________

State ____ ZIP Code ________ +4 ______

## Section 3 – Waiver of Insurance Coverage

The group insurance has been offered to me, and I am waiving my right to participate in the coverages marked below:

**Life Insurance:**

☐ Basic Term Life and Accidental Death & Dismemberment (AD&D)

☐ Voluntary Term Life (and AD&D, if applicable)

Please tell us why ________

☐ Dependent life

Please tell us why ________

**Disability Insurance:**

☐ Short Term Disability

☐ Long Term Disability

Please tell us why ________

## Section 4 – Authorization

I understand that by waiving life and/or disability insurance for myself (and my dependents if my employer offers Dependent Life), I am giving up the right to be covered without being medically underwritten. If I decide to enroll later, I will be responsible for paying any expense necessary to determine my insurability (or that of my dependents) including, but not limited to, the expense of obtaining medical records or medical exams. AICK will determine whether I (or my dependents) may be insured; and I recognize that I (or my dependents) may be at risk for being declined coverage.

**Your signature required** ________ Employee ________ Date Signed _____ /_____ /_______

**Group's signature required** ________ Person Authorized to Sign for Employer



An independent licensee of the Blue Cross Blue Shield Association.