CHRISTIAN BROTHERS SERVICES

Employee Benefit Trust
1205 Windham Parkway
Romeoville, IL 60446
800.807.9460 / 630.378.3005 fax

Request for Waiver of Medical/Dental/ Vision (Optional Benefits)

When to use this form: An eligible employee still actively working at your location and is enrolled for Life, LTD, and optional benefits (medical/dental/vision), but now wants to waive (decline) his/her optional benefits. (Refer to "Your Employee Benefit" booklet for eligibility definition.) **DO NOT USE TO DROP ANY PART OR ALL OF DEPENDENT COVERAGE.**

Location Name	Location Number

Name (Last, First, Middle Initial)	Social Security Number

I hereby certify that I have requested my employer to waive (decline) my optional benefits

☐ Medical ☐ Dental ☐ Vision

You must complete one of the following – Coverage is being waived because:

☐ Employee enrolled on spouse's plan
☐ Employee enrolled in employer provided HMO
☐ Employee covered by another employer
☐ Employee has own individual policy
☐ Medicare
☐ Other, please explain:

Effective Date*	Signature of Employee	Date	Administrator's Approval

**** This form must be sent within 31 days of the effective date.***

1/2025