Total Waiver

Please mail original completed form to BBD:
Western Canada
500-2755 Lougheed Highway, Port Coquitlam, BC V3B 5Y9
Fax: 604.464.7997 Toll Free: 800.667.1336
Eastern Canada
107 – 6 Cataraqui Street, Kingston, ON K7K 1Z7
Fax: 613.530.3770 Toll Free: 888.272.0414

Name of Employer:

▶ *Total Waiver is not allowed under all group plans. If allowed, it requires a witness to the employee's signature, and certification by the employer.* ◀

▶ *PLEASE PRINT. Submit original form only — fax copies or photocopies cannot be accepted.* ◀

▶ Employee – Complete this section ◀

Employee Last Name	First Name	Initial	Are you covered under your Provincial Health Plan? ☐ Yes ☐ No

I certify that I have been provided with a description of the benefits included in my employer's group insurance plan, and my rights with respect to coverage thereunder. I elect to waive all benefits available to me and my dependents under this plan.

▶ *IMPORTANT NOTE* ◀

For a Total Waiver, your signature must be witnessed by someone over the age of 18 who is not related to you.

I understand that I will not be insured, nor will my dependents, for any benefits under my employer's group insurance plan. I further understand that if I wish to apply for coverage at a later date I will be required to furnish, at my own expense, evidence of insurability satisfactory to the insurer(s) for both me and my dependents. All coverage is subject to the approval of the insurer(s) and any terms or conditions they may impose at the time of such approval.

X _____
Signature of Employee Date

X _____
Signature of Witness Date

▶ Employer – Complete this section ◀

▶ *IMPORTANT NOTE* ◀

For a Total Waiver, the employer must certify that all requirements have been fulfilled.

On behalf of the employer, I certify that all of the following conditions of Total Waiver by an employee have been satisfied:

1) The minimum enrolment requirements for our group have been met.
2) Our employees contribute to the cost of our group insurance plan.
3) Coverage under our group insurance plan is not a condition of employment.

X _____
Authorized Signature of Employer Date

_____
Name Title