



Partial Waiver

Western Canada
 500-2755 Lougheed Highway, Port Coquitlam, BC V3B 5Y9
 Fax: 604.464.7997 Toll Free: 800.667.1336

Eastern Canada
 107-6 Cataragui Street, Kingston, ON K7K 1Z7
 Fax: 613.530.3770 Toll Free: 888.272.0414

Name of Employer:

- *To use this form you must already be insured under your employer's plan.* ◀
 ► *For a new enrollment complete a Group Insurance Enrollment form.* ◀

► Employee – Complete for partial waiver due to coverage under another group plan ◀			
Employee Last Name	First Name	Initial	Are you covered under your Provincial Health Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No
I elect to waive the benefits checked below because comparable coverage is provided to me and/or my dependents under another group plan: (specify plan details below)			
► For myself and my dependents..... <input type="checkbox"/> Extended Health Care <input type="checkbox"/> Dental Care <input type="checkbox"/> Health Care Spending Account		OR	► For my dependents only <input type="checkbox"/> Extended Health Care <input type="checkbox"/> Dental Care <input type="checkbox"/> Health Care Spending Account
Name of Other Plan's Employer/Policyholder		Is this your spouse's group plan? <input type="checkbox"/> Yes <input type="checkbox"/> No (if no, provide details) _____	
Name of Insurance Company			
Group Number	Identity Number		