

**Election to Waive Coverage Under
The Catholic Diocese of Cleveland
Program of Health Care Benefits**

I, _____, hereby certify that as a current employee
Please Print Clearly

of _____, I have been given the
Employing Parish or Institution

opportunity to participate in the Catholic Diocese of Cleveland Program of Health Care Benefits (the "Plan"), and that I hereby elect to waive such coverage for myself and my dependent(s), if any.

• Reason for waiving coverage: _____

• If you are waiving coverage because you and your spouse are covered under a plan of another employer, please indicate:

Spouse's Employer: _____
Carrier of Group Plan: _____

• If you are waiving coverage because of present coverage elsewhere, please indicate:

Name of Insurance Carrier: _____
Contract Number: _____
Group Number: _____
Effective Date: _____
Single Coverage () Family Coverage ()

I understand that as long as this waiver remains in effect, neither I nor my dependent(s), if any, will be entitled to any benefits under the Plan.

I further understand that I may revoke this waiver of coverage after its effective date and again become eligible to participate in the Plan by one of the following methods:

- By making a proper election for benefits during any of the Plan's future open enrollment periods; or
- By showing evidence which is satisfactory to the Employee Benefits Department of the Diocese of Cleveland that your health benefit coverage elsewhere was involuntarily terminated, such as your coverage being terminated as a result of your spouse's termination of employment.

Signature of Employee

Date

Signature of Witnessing Plan Representative