☐ *Altran Solutions Corp.*

Insurance Waiver Form

EMPLOYEE INFORMATION			
NAME (First, MI, Last)		SOCIAL SECURITY #	EMPLOYEE ID #
ADDRESS (Street)	(City)	(State)	(Zip Code)
DAYTIME TELEPHONE #		Date of Birth (DOB)	

Insurance Waiver

HEALTH

☐ I **elect** to decline Medical Coverage at this time

I am aware that I am eligible to elect medical coverage at a later date under the following circumstances:

1. A Qualifying Event: Loss of other coverage through no fault of your own, i.e., spouse's loss of job
2. Medical Annual Open Enrollment.

DENTAL **Guardian Plan# 399709-0000**

☐ I **elect** to decline Dental Coverage at this time

I am aware that I am eligible to elect dental coverage at a later date under the following circumstances:

1. A Qualifying Event: Loss of other coverage through no fault of your own, i.e., spouse's loss of job
2. Dental Annual Open Enrollment.

I am aware that I can elect coverage anytime after open enrollment; however I will be subject to "Late Entrant" penalties described in the Guardian Dental Plan Summary.

VISION

☐ I **elect** to decline Vision Coverage at this time

I am aware that I am eligible to elect vision coverage at a later date under the following circumstances:

1. A Qualifying Event: Loss of other coverage through no fault of your own, i.e., spouse's loss of job
2. Vision Annual Open Enrollment.

VOLUNTARY LIFE

☐ I **elect** to decline Voluntary Life Coverage at this time

I am aware that I am eligible for Voluntary Life coverage at a later date but must meet Evidence of Insurability.

HEALTH FSA

☐ I **do not wish to participate** in the Health Flexible Spending Account.

DEPENDENT CARE

☐ I **do not wish to participate** in the Dependent Care Plan.

Signature

Signature: ____ Date: ___/___/_____

Please sign, date and return to Human Resources