Fulton County Finance Form
WAIVER OF INSURANCE BENEFITS

EMPLOYEE NAME

SOCIAL SECURITY NUMBER

DEPARTMENT

WAIVING INSURANCE BENEFITS FOR:

(•) **SELF** ( ) **SPOUSE** ( ) **SELF AND SPOUSE**

WAIVER OF BENEFITS FOR SELF

I, the undersigned, understand that I have been given an opportunity to apply for Health, Dental and/or Vision benefits as offered by my employer and after careful consideration, have decided to waive the following types of insurance coverage:

☐ **MEDICAL** ☐ **DENTAL** ☐ **VISION**

I have attached proof of other coverage (insurance card). I understand that I will not be eligible to participate in the health, dental and/or vision benefits program offered by my employer from the effective date of this waiver until the next annual enrollment period.

WAIVER OF BENEFITS FOR SPOUSE OF EMPLOYEE

SPOUSE'S NAME:

SPOUSE'S SOCIAL SECURITY NUMBER:

I understand that I have been given an opportunity to apply for Health, Dental and/or Vision benefits as offered by my employer and after careful consideration, have decided not to take advantage of this offer because my spouse, an employee of Fulton County, has elected to provide my Health, Vision and Dental Benefits as offered by Fulton County.

I understand that if my spouse discontinues this coverage that I will be required to participate in the health, dental and/or Vision benefits as offered by my employer from the date of discontinuance, and I agree to notify my employer if my coverage has been discontinued so that my coverage will begin the date that my spouse discontinues coverage.

EMPLOYEE SIGNATURE: _____

DATE: