MEMBERS' INSURANCE TRUST

P.O. Box 11188
Columbia, SC 29211

1-800-327-1021
803-731-4021 Fax

www.scmamit.com

Waiver of Coverage Form

I hereby waive participation in the South Carolina Medical Association Voluntary Employees' Beneficiary Association Welfare Benefit Plan and Trust (MIT) medical and/or dental coverage. I acknowledge that I have been offered the opportunity to participate in MIT and that I have been provided sufficient information about MIT to make an informed decision regarding my decision not to participate. I have chosen to decline this offer and waive coverage for the following reason:

Medical Insurance Coverage	Dental Insurance Coverage
□ I have medical coverage through my spouse. List Carrier Name: _____ □ I have medical coverage through the Exchange. □ I have other group medical coverage. List Carrier Name: _____ □ I have other individual medical coverage. List Carrier Name: _____ □ I have Medicare. □ I have Medicaid. □ I have TriCare. □ Other: _____ _____	□ I have other dental coverage. List Carrier Name: _____ □ Spouse has other dental coverage. □ Other: _____ _____

If you are declining enrollment for yourself or your dependents (including your spouse) because of other medical or dental insurance or employer group health plan coverage, you may be able to enroll yourself and your dependents In MIT if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, your request for enrollment must be in writing and received by MIT within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage), subject to all applicable rules.

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, your request for enrollment must be in writing and received by MIT within 31 days after the marriage, birth, adoption or placement for adoption, subject to applicable rules.

MIT reserves the right to request proof of other coverage.

Employee Social Security Number	**Employee Date of Birth**
Employee Address	**Employee Date of Hire & Average Working Hours**
Print **Employee** Name	Participating Employer
Employee Signature	Date