



Chambers of Commerce
Group Insurance Plan®

GROUP BENEFIT PLAN WAIVER

I, _____, have been offered the opportunity to participate in my employer's
(Name)

employee benefit program. I understand the benefits offered and I do not wish to enroll in the program.

I understand that by refusing these benefits, my heirs / beneficiaries and I have no claim, now or in the future, for benefits under the program. I hold my employer, its representatives and the insuring company(ies) harmless from all future claims.

I also understand that if I wish to participate in the employee benefit program at a later date, participation will be subject to the insurer's approval. I may be required to provide evidence of my good health and/or my dependents' good health.

Dated at _____ in _____, this _____ of _____ 20 _____.
town/city province day month year

Employee's Signature

Witness

Spouse's Signature (if applicable)

Witness