Benefits made easy

An Amwins Company

CoPower Waiver/Declination Form

Use this form to waive/decline CoPower One, Dental and/or Vision coverage. Please complete the form and submit to CoPower via E-mail at copower.requests@amwins.com or via fax at **650.348.1149**

Employee Information

Employee Name: Member SSN: - -

Employer Name: CoPower ID Number:

I have been notified of my eligibility for enrollment in my employer's Dental and/or Vision benefit program listed below:

Benefit Program

☐ CoPower One (Bundle) ☐ Dental ☐ Vision

Action

I voluntarily decline to enroll myself due to the following reason:

☐ **Waiving Coverage:** Covered by another plan.

Dental Carrier Name: ID Group Number:

Vision Carrier Name: ID Group Number:

☐ **Declining Coverage:** I do not have other coverage and decline to enroll.

I acknowledge that I will be unable to enroll at a later date unless I show proof of loss of coverage under another dental/vision plan, or the group plan contract allows me to enroll during the company's open enrollment period (if applicable). In the event that I do lose coverage under another plan, I understand I must enroll with my employer's dental/vision plan on the first day of the month after loss of coverage.

A written request must be submitted no later than 30 days following termination of that coverage with proof of loss.

Signature

Employee's Signature: _____ Date: / /

Employer's Signature: _____ Date: / /