

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: / /