Vision Waiver Form

Use for Vision Non-Voluntary Programs

Please fill out completely and submit to CoPower via fax at 650.348.1149 or email at requests@copower.com.

Member Information	
Member Name:	Member Social Security Number:
Employer Name:	CoPower ID Number:

Reason for Waiving Coverage

Eligible members may refuse vision coverage only if they are covered by another vision program (i.e. spouse's program or individual plan).

☐ Covered by other vision coverage

Carrier Name: _____ Group/ID Number: _____

I have been notified of my eligibility for enrollment in my employer's vision benefit program. However, I voluntarily decline to enroll. By signing below, I certify that the reason I am waiving enrollment in this vision plan benefit is that I am currently covered under another vision program.

I acknowledge that if I and/or my eligible dependents lose coverage under group vision program, I must request that I and/or my dependents be enrolled in my employer's vision benefit program. A written request must be submitted no later than 30 days after the termination of that coverage with proof of loss.

Signature	
Member Signature	Date:
Employer Signature:	Date: