

WAIVER OF BENEFITS

RETURN THIS TOP PORTION IF YOU DO NOT WISH TO BE ENROLLED ON ONE OR MORE OF THE GROUP INSURANCE POLICIES

NAME: _____ ELIGIBILITY DATE: _____

If you do not wish to be enrolled on one or more of our group insurance policies, please indicate below; date, sign and return this form to Waco's Sandston Office, Attn: Vickie Corson

- I DO NOT** wish to be enrolled on Waco's group health insurance plan.
- I DO NOT** wish to be enrolled on Waco's group life insurance plan.
- I DO NOT** wish to be enrolled on Waco's group long-term disability plan

Date

Signature

LONG-TERM DISABILITY INSURANCE (Assurety)

YES, I am interested in hearing more about the disability insurance. I understand I may be contacted by an agent to complete the application process.

NAME: _____ HOME PHONE: _____

ADDRESS: _____

DATE OF BIRTH: ____/____/____ DATE OF HIRE: ____/____/____ SMOKER(Y/N): ____

OCCUPATION: _____ JOB-SITE LOCATION: _____

SIGNATURE: _____ DATE: _____

*******YOU MUST RETURN THIS BOTTOM PORTION IF YOU ARE INTERESTED IN THE DISABILITY PLAN**