Benefits Waiver of Coverage

Please note: Review all beneifts options prior to submitting this form. Details have been sent to you in the mail. If you would like guidance on beneift options please contact Universe at *www.benefitsgo.com/WinnNewHire.*

This form will must be submitted to the hrhelpdesk@winnco.com within 120 days of your employment. Please note failure to complete this form could delay your enrollment in benefits.

Employee Information:				
First Name:	M.I.	Last Name:	D.O.B	Sex: ☐ M ☐ F
Street Address:	Apt. #	City:	State:	Zip Code:
SSN:	Date of Hire:		Date of Eligibility:	
Home Telephone:	Cell Phone:		Email:	

Medical:

☐ I wish to opt out of the medical coverage plan and acknowledge that I cannot enroll until the next open enrollmentperiod, July of the following year unless I have a life changing event

Signature: _____ Date: _____

Dental:

☐ I wish to opt out of the dental coverage plan and acknowledge that I cannot enroll until the next open enrollmentperiod, July of the following year unless I have a life changing event

Signature: _____ Date: _____

Vision:

☐ I wish to opt out of the vision coverage plan and acknowledge that I cannot enroll until the next open enrollment period, July of the following year, unless I have a life changing event.

Signature: _____ Date: _____

IMPORTANT: The Affordable Care Act requires that any individual declining coverage complete a waiver of coverage. Employees who decline coverage that is considered affordable and adequate under the Patient Protection and Affordable Care Act will not qualify for government subsidies to purchase individual health insurance.

By signing you are acknowledging that you are electing not to enroll in the WinnCompanies medical plans.

Print Name:_____

Signature: _____**Date:** _____