WAIVER OF PARTICIPATION
IN
THE CITY OF ROME
EMPLOYEE
BENEFITS PROGRAM

I, the undersigned, an employee of the City of Rome, certify that I have been given an opportunity to enroll in the Employee Benefits Program. I understand that these benefits are offered to employees and their dependents on a contributory basis. After careful consideration, I have decided not to elect benefits as checked below.

I realize that by declining such coverage, I am giving up my right to recover any deductible, coinsurance or non-covered allowable expense available to me or to my dependents due to coordination of benefits with any other plan.

I understand that if I desire coverage in the future I can only elect coverage during the open enrollment periods that are scheduled twice a year. I will be required to furnish Evidence of Insurability satisfactory to the Plan Administrator and the Plan Administrator reserves the right to refuse to grant such coverage. Furthermore, I understand that coverage will not become effective until required medical information is received and reviewed by the Plan Administrator.

I waive: **Medical Benefits for myself_____**
Dependent Coverage _____

_____
_____
Signature of Employee
(Print Full Name & Sign)

_____
Employer Authorization

_____
_____
Signature of Spouse
(Print Full Name & Sign)

_____1/1/2015_____
Effective Date

THIS FORM MUST BE COMPLETED & RETURNED TO THE INSURANCE OFFICE TO BE VALID