FORT DEARBORN LIFE INSURANCE COMPANY

Waiver of Coverage

BlueCross/ BlueShield of Illinois

Please complete this form if you are waiving any coverage. If you are not declining any coverage, please do not complete this form.

Employer Name			Employee social security *	
Nagle Hartray Danker Kagan McKay Penney Architects Ltd.				
Employee Last Name	First Name			M I
Street Address	Apt. #	City	State	Zip Code

If you are declining health or dental coverage for yourself, your spouse or your children because of other coverage, you may m the future be able to enroll yourself, your spouse and/or your children in this plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new spouse or child as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and diem, provided you request enrollment within 31 days of the marriage, birth, adoption or placement for adoption. *I acknowledge that I, along with my spouse and for children (if any), were provided an opportunity to enroll in my employer's Group Health, Life and Dental Insurance plans.*

I DO NOT WISH TO ENROLL FOR: (check all that apply)

Health Plans

☐ I do not wish to enroll for Health coverage. I hereby elect not to enroll in the Group Health Insurance plan for the reason indicated below and understand that the opportunity to enroll at my future time will be subject to such arrangements as may be made available with the Company.

Reason:

☐ Covered under spouse's employer-based health insurance plan (Please complete "Other Insurance Information" section below)

☐ Covered under a Medicare supplement plan

☐ Other (please explain,) _____

Your signature is required below for any waiver of coverage.

BlueCare Dental Options

☐ I do not wish to enroll for Dental coverage.

Your signature is required below for any waiver of coverage.

Fort Dearborn Life (FDL)

☐ I do not wish to enroll for Life coverage.

☐ I do not wish to enroll for Short Term Disability coverage.

Your signature is required below for any waiver of coverage.

If you are waiving any or all coverages offered, please remember to complete the "not enrolling" boxes for the coverage types you are waiving.
Your signature is required for any waiver of coverage.

Other Insurance Information: Complete ONLY if YOU have other group coverage.

If you or any of your family members have other group coverage please complete the following section. Check all that apply.

Health coverage for: ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other Policy Number _____ ☐ Single ☐ Family			
Name of Insured:	SSN: __ __ __ / __ __ /__ __ __ __		Date of Birth: ___/__/_____
Employer Name:	Name and Address of Insurance Company:		
City	State	Zip	Telephone #

Dental coverage for: ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other Policy Number _____ ☐ Single ☐ Family			
Name of Insured:	SSN: __ __ __ / __ __ /__ __ __ __		Date of Birth: ___/__/_____
Employer Name:	Name and Address of Insurance Company:		
City	State	Zip	Telephone #

Signature of Employee: _____ Date: _____