

# W A I V E R

## HEALTH and/or DENTAL<sup>1</sup> COVERAGE

TO: CITY OF MILWAUKEE/EMPLOYEE BENEFITS DIVISION (EBD)

I, \_\_\_\_\_, the undersigned, understand I am eligible for health and/or  
(print name)  
dental coverage through the City of Milwaukee. By execution of this waiver form, I hereby waive my rights to health and/or dental coverage by checking the appropriate box below, signing and dating this form. I understand that if I should want such coverage in the future, I may be required to wait until the next open enrollment period to enroll.

If you have any questions about this form, contact EBD at 286-3184.

<p><b><u>Please check (√) appropriate box (only one box):</u></b></p> <p><input type="checkbox"/> I elect to waive <b><u>only</u></b> my health coverage</p> <p><input type="checkbox"/> I elect to waive <b><u>only</u></b> my dental coverage</p> <p><input type="checkbox"/> I elect to waive <b><u>both</u></b> my health and dental coverage</p> <p><b><i>REASON FOR WAIVER</i></b> _____</p>
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SOCIAL SECURITY NUMBER \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

EMPLID or PENSION NO.: \_\_\_\_\_ Dept/Div: \_\_\_\_\_

CANCEL EFFECTIVE DATE (1<sup>st</sup> of Month only) \_\_\_\_\_

EMPLOYEE SIGNATURE: \_\_\_\_\_ DATE SIGNED: \_\_\_\_\_

**NOTE:** *Return this form to your payroll clerk who will notate your record and forward a copy to EBD.*

<sup>1</sup> If your spouse also works for the City of Milwaukee, you must comply with the “one family plan” rule.