

Waiver of Medical and/or Dental Coverage Group Plans

For new Group Plans participants: If coverage is fully paid for by your employer, you must complete this form to waive (decline) medical and/or dental coverage for both you and your dependents under Group Plans.

For existing Group Plans participants: If you waive medical/dental coverage in which you and/or your dependents are already enrolled, one of the following applies:

- **For employer-paid coverage (employee only coverage or employee, dependent or family coverage):** Paid coverage will end on the last day of the month if GuideStone receives your completed waiver form by the 10th of the month.
- **For employee-paid coverage (dependent coverage):** Coverage will end on the last day of the month through which the employee has paid for coverage ("paid-through date"). Please provide the "paid-through date" in the section below.

CERTIFICATION AND WAIVER

Employer: Henderson Hills Baptist Church Employer number: 411 23

Employee name: Kaycie Beth Craig Social Security number (last four digits): 5494

This is to certify that I have been given the opportunity to apply for or continue medical and/or dental coverage provided to me and/or my dependents at no cost to me by my employer. I have not and will not receive any financial or other incentives from my employer in exchange for waiving coverage. I understand that my dependents are not eligible for coverage if I waive coverage for myself.

I waive medical coverage for:

☐ Myself

For employee-paid dependent coverage, please provide employee

"paid-through" date: 06 / 30 / 12 (mm/dd/yyyy)

☒ Myself and all eligible dependents

☐ All eligible dependents

☐ Only these dependents:

Social Security number (last four digits): _____ Name: _____

Social Security number (last four digits): _____ Name: _____

Social Security number (last four digits): _____ Name: _____

I waive dental coverage for:

☐ Myself

☒ Myself and all eligible dependents

☐ All eligible dependents

☐ Only these dependents:

Social Security number (last four digits): _____ Name: _____

Social Security number (last four digits): _____ Name: _____

Social Security number (last four digits): _____ Name: _____

Reason for waiving:

☒ Other group medical coverage

☐ Other individual medical coverage

☐ Other (explain): _____

Reason for waiving:

☒ Other group dental coverage

☐ Other individual dental coverage

☐ Other (explain): _____

I understand that if I ask for coverage later, the terms of the plans will control my ability to get coverage. I also understand that pre-existing condition exclusions, waiting periods and other limitations may apply.

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Employee signature: Kaycie Craig Date: 6/19/12
Employer representative: Paula Mikes Date: 6/21/12

Special enrollees for medical coverage: Under federal law, if you decline enrollment for medical coverage for yourself or your dependents because of other medical (not dental) coverage, you may in the future be able to enroll yourself or your dependents as special enrollees in Group Plans. Also, if you acquire a new dependent due to marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents as special enrollees. To enroll as a special enrollee for medical coverage, you must request enrollment within 60 days after your other coverage ends or within 60 days after the marriage, birth, adoption or placement for adoption. These rules do not apply for dental coverage.

Late enrollees: If you or your dependents do not enroll when first eligible or as a special enrollee as described above, you or your dependents may enroll as a "late enrollee" under the plans. You may enroll as a late enrollee for medical coverage during any re-enrollment period. Coverage will become effective on the January 1 after GuideStone receives your enrollment form.

Note: Please see the plan booklets for information about pre-existing condition exclusions, waiting periods and other limitations for special and late enrollees.