



Waiver/Verification of Other Medical & Dental Coverage

Employee Name _____ Social Security Number _____

I understand that I am eligible for Medical and Dental coverage provided by MedStaff. The medical and dental benefits under such plans and the contributions I would have to make to be covered for these benefits have been explained to me in detail.

I certify that I have medical and/or dental benefits under another group insurance plan: Medical Dental

Full name of principal insured (and relationship) _____

Name of organization providing coverage (i.e., an employer) _____

Address _____

Insurance Carrier _____

Group Number _____

I therefore decline coverage for the full year of April 1, 2010 through March 31, 2011 under the medical and/or dental plans offered by MedStaff for myself and any eligible dependents unless otherwise stated in my employment contract.

- I waive all claims to medical benefits under the MedStaff Healthcare Plans.
- I waive all claims to dental benefits under the MedStaff Healthcare Plans.

I understand that if I choose to enroll for the benefits at a later date, I (and/or my dependents) may be subject to limitation for pre-existing conditions and required to furnish evidence of good health in order to be covered. Under some circumstances, coverage may be denied. Coverage will only be available during the annual open enrollment period, unless you experience a qualifying life changing event. In these circumstances, you must enroll within 30 days of the qualifying event. Please note, pre-existing condition limitations may apply.

I further understand that, as a result of this waiver, no medical and/or dental coverage under any of the MedStaff Health Plans will be provided. I hereby release, and hold MedStaff, and any health and/or dental plans of MedStaff, and any Administrators of said plan, harmless for any claims as a result of the failure of refusal to provide medical and/or dental benefits in accordance with this waiver.

I declare that the information I have furnished above, to the best of my knowledge and belief, is true, correct, and complete; and I agree that medical benefits under MedStaff Healthcare Plans will be denied for my submission of any false information on this Verification or any other form.

Witness

Employee Signature

Date