THE McCLATCHY COMPANY
Since 1857

Waiver of Insurance Form

WAIVER OF COVERAGE (Complete this section if you declined medical, dental or vision coverage)

NAME: _____ Employee ID#_____

I am declining coverage for the following:

Myself	☐ Medical	☐ Dental	☐ Vision	
My Spouse/DP	☐ Medical	☐ Dental	☐ Vision	Spouse/DP's Name: _____
My Dependent(s)	☐ Medical	☐ Dental	☐ Vision	Dependent's Name(s): _____
				Dependent's Name(s): _____
				Dependent's Name(s): _____
				Dependent's Name(s): _____

☐ The individual(s) declining coverage is covered by alternate health care plan; Name of Carrier: _____

_____

I have been notified that I, my spouse/Domestic Partner (if applicable), and any dependents I may have, are eligible for enrollment in my employer's health care benefit plan. By signing below, I voluntarily decline to enroll the individuals shown above, acknowledging that my failure to now elect coverage permits my employer's health care benefit plan to impose a twelve month exclusion from coverage following application should these individuals later apply for coverage.

_____ _____

Please sign your name. Do not print. **Date**

Please return this completed form to the Human Resources Department