MANNING PERSONNEL GROUP, INC.
VERIFICATION OF ALTERNATIVE COVERAGE

Please fill out this form completely if you are waiving coverage.

Employee Information

Employee Name:____

Social Security Number:____

Reasons for Waiver

I waive my right to participate in any coverage offered by Manning Personnel Group, Inc. offered at this time because:

- ❑ I am covered under my spouse's health plan.
- ❑ I am covered under another health plan sponsored by my previous company (COBRA).
- ❑ I am covered by Medicare.
- ❑ I do not wish to participate at this time. (Must provide details) ____________________
- ❑ Other: (**Must** provide details)____
- This is a simple survey question for our renewal pricing ONLY (but it is required):
  If you were to elect coverage through Manning Personnel Group, would you elect (please check one):
  - ❑ Employee Only
  - ❑ Employee + Spouse
  - ❑ Family

Signature

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact Manning Personnel Group, Inc.

I understand that if I choose to enroll, I must meet requirements, if any, applicable to late enrollees.

____

Name

______________________________ ____________________

Signature Date