



SERVICE REQUIREMENT WAIVER FORM

Association Name: _____

Employee to be Waived: _____

Date of Hire: _____

Desired Date of Coverage: _____

Normal Service Requirement: _____

Reason for Waiver: _____

COVERAGES:

Please circle applicable coverage.

Life Salary: _____ Insured Amt: _____

Voluntary Life Salary: _____ Insured Amt: _____

LTD Salary: _____

Medical Contract Type: _____

Dental Contract Type: _____

Vision Contract Type: _____

Other _____

Requested by: _____

Please print Name & Title

Authorized Signature: _____ Date: _____