W A I V E R

HEALTH and/or DENTAL[1] COVERAGE

TO: CITY OF MILWAUKEE/EMPLOYEE BENEFITS DIVISION (EBD)

I, _____, the undersigned, understand I am eligible for health and/or
(print name)
dental coverage through the City of Milwaukee. By execution of this waiver form, I hereby waive my rights to health and/or dental coverage by checking the appropriate box below, signing and dating this form. I understand that if I should want such coverage in the future, I may be required to wait until the next open enrollment period to enroll.

If you have any questions about this form, contact Employee Benefits Division (EBD) at 286-3184.

Please check (√) appropriate box (only one box):

☐ I elect to waive **only** my health coverage

☐ I elect to waive **only** my dental coverage

☐ I elect to waive **both** my health and dental coverage

REASON FOR WAIVER _____

SOCIAL SECURITY NUMBER ____ ____ ____- ____ ____- ___ ___ ___ ____

EMPLID NO. *(6 digit)*: _____ Dept/Div: _____

CANCEL EFFECTIVE DATE (1st of Month only) _____

EMPLOYEE SIGNATURE: _____ DATE SIGNED:_____

NOTE: *Return this form to EBD, Room 701, City Hall.*

[1] If your spouse also works for the City of Milwaukee, you must comply with the "one family plan" rule.

Original Date 1/83 *(R. 12/08/09)*