EMPLOYEE REFUSAL FORM

Policy No.:_______________ Account:__________ Company Name:__________________________________

Employee Name:____
(Last) (First) (Initial)

Social Insurance Number:_____________________ Birthdate:________________ Hire Date:_______________
Month / Day / Year *Month / Day / Year*

I have been given the opportunity to participate in the Group Benefit Plan offered by my employer, under the above Policy No. I do hereby refuse to participate in the following effective ______________________:
Month / Day / Year

☐ All the benefits of my employer's Group Plan ☐ Excess Risk Long Term Disability

☐ *Extended Health Benefits ☐ *Dental

*Refusal of this benefit is allowed ***only*** if coverage is provided through another plan**:

**Other Plan Details: Insured Name:________________________ ID#:__________________________

Insurance Co:________________________ Policy #:__________ EHC ☐ Single ☐ Family DEN ☐ Single ☐ Family

It is understood that:

- if I request any refused benefit at a later date, satisfactory evidence of insurability, at my own expense, may be required.
- if my employer's Group Benefit Plan includes dental benefits, there may be a significant limitation applied from the date dental coverage is approved.

DATE:___________________ EMPLOYEE SIGNATURE:_________________________

Please return signed refusal form to: Automotive Retailers Association
1 – 8980 Fraserwood Crt
Burnaby BC V5J 5H7
Ph#: (604) 419-3629
Fax #: (604) 419-0299

ADM 08 (04-10)