AUTOMOTIVE RETAILERS ASSOCIATION
Driving Industry Excellence

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.
I do hereby refuse to participate in the following, effective _____ ***Month / Day / Year***

ALL

☐ *Waive all benefits of my employer's Group Plan. I have alternate coverage.

SELECT

Waive the following benefit(s) of my employer's Group Plan. I have alternate coverage.

☐ *Extended Health Benefits ☐ *Dental

* **Must show proof of alternate coverage to waive ALL or SELECT benefits.**

Alternate Plan Details: Insured Name:_____ ID#:_____

Insurance Co:_____ Policy #:_____

It is understood that:

- If I request reinstatement of any refused benefit at a later date, satisfactory evidence of insurability, at my own expense, may be required and coverage may be denied.
- If dental benefits are reinstated 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
Unit1 – 8980 Fraserwood Crt,
Burnaby BC V5J 5H7

Ph#: (604) 419-3629
Fax #: (604) 419-0299