ELECTION WAIVER FORM

National Associates, Inc

Employee Name	Social Security Number

Contract/Jobsite Location	Date of Hire

Please note: This form only applies to those participants currently enrolled in a group major medical plan who choose not to participate in the **Aetna Net Premier Plan(s) Aetna Affordable Health Choices® limited benefits insurance plan**. Please make a copy of the front and back of your current insurance identification card and attach the copy to this form for verification purposes.

You must submit this Election Waiver Form, along with your proof of other group major medical coverage, within 30 days from your Date of Hire. Failure to do so will result in you being defaulted as Employee Only in the **Aetna Affordable Health Choices® limited benefits insurance plan Aetna Net Premier Plan(s)**. Please be aware that if you do not submit the Election Waiver Form within 30 days from your date of hire, you will not be given an opportunity to waive this plan until a subsequent enrollment period or you experience a qualifying life event

Waiver of Coverage

I understand that by choosing to NOT participate in the **Aetna Affordable Health Choices insurance plan Aetna Net Premier Plan(s)**, I am waiving coverage under the plan available to me and my eligible dependents through **National Associates, Inc**. I also understand that I am making a binding election with respect to my benefits and I will not have an opportunity to enroll in the plan unless I experience a qualifying life event.

Signature Date