

WAIVER OF COVERAGE FOR GLOBAL PLANS

Employee Name: _____

Company: _____

Hire Date: _____

Eligibility Date: _____

Coverage(s) declined for:

MEDICAL: Myself Spouse/Domestic Partner Child(ren)
DENTAL: Myself Spouse/Domestic Partner Child(ren)
VISION: Myself Spouse/Domestic Partner Child(ren)

Reason for declining coverage: (please check one)

- Covered under another employer health benefit plan (e.g., through spouse, domestic partner)
Carrier Name: _____ (attach copy of ID card)
- Covered under an individual plan through a separate health carrier
Carrier Name: _____ (attach copy of ID card)
- Other: _____

125 FLEXIBLE SPENDING ACCOUNTS: Dependent Care Health Care Reimbursement
 401K:

I have been notified that I, and any dependents that I may have, are eligible to enroll in any MMC, Inc. sponsored group health plan coverage. I now decline to enroll in the MMC, Inc. health plan(s) as indicated above.

If I acquire a new dependent as the result of marriage, birth, adoption or placement for adoption, I acknowledge that I, and any dependents that I may have, may request enrollment in any of MMC, Inc.'s group health plans by applying for that coverage within 30 days of the marriage, birth, adoption, or placement for adoption. Otherwise, I acknowledge that MMC, Inc.'s group health plan(s) may exclude coverage for 12 months and impose a six-month pre-existing condition exclusion if I or any dependents I may have, later decide to request enrollment in one of MMC, Inc.'s group health plans.

If I have indicated above that the reason for declining coverage for myself and/or my dependent(s) is coverage under another health benefit plan, I acknowledge that if these individuals involuntarily lose coverage under the other employer's health benefit plan, I must request enrollment for them in MMC, Inc.'s group health plan within 30 days. Otherwise, I understand that MMC, Inc.'s group health plan may impose a twelve-month exclusion from coverage following the application and a six-month preexisting condition exclusion upon enrollment.

X _____
Employee Signature

Date