ODA Wellness Trust

Administered by

MEDICAL MUTUAL

Pleasesendformsto:

Ohio Dental Association Services Corporation
1370 Dublin Rd.
Columbus, OH 43215
Phone: 614-486-2700
Fax 614-340-9444

HEALTH BENEFIT WAIVER

This benefit waiver is available to employees who are regularly scheduled to work a minimum of 25 hours or more every week. Upon renewal of the Group Health Plan, employees may elect to continue to waive out or enroll in the benefit program during the open enrollment period, or at any time upon a qualifying event as defined in the Plan's Summary Plan Description.

WAIVER

I, _____ voluntarily agree to waive coverage under the health benefits offered by _____. I understand the above explanation of my rights to waive benefits or enroll in the benefit program offered.

Choose one of the below options that apply:

_____ I knowingly do not have any type of health (medical, vision & prescription drug) benefits and do not wish to participate in the Group Health Plan being offered.

_____ I certify that I am covered by the following health insurance plan:

Name of Health Insurance Plan:_____

Company or Group Sponsor: _____

I understand that if I purchase individual health insurance, it must not be paid for with pre-tax dollars, and any contribution from my employer toward my health insurance will be considered part of my salary and taxed as such.

_____ _____

Employee Signature Date

_____ _____

Employer Signature Date

Account #: _____

To be completed by Plan Administrator

V.ODAWT.9.14