[EXHIBIT T]

[CARRIER]

SMALL EMPLOYER HEALTH BENEFITS WAIVER OF COVERAGE

Group Policy No. _____

Policyholder Name _____

Employee Name _____
Last First MI

Marital Status:___Single ___Married ___Widowed ___Divorced

Date of Employment _____ Date of Birth _____

I was given the opportunity to enroll in this plan of group health benefits offered by my employer and insured by [Carrier]. I refuse the following:

____ Employee, Spouse and Child(ren) coverage

____ Spouse coverage

____ Child(ren) coverage

Reason for Refusal (Please check all appropriate lines)

____ other Group Health Plan sponsored by this employer

____ other Group Health Plan sponsored by my spouse's employer

____ other Group Health Plan sponsored by another organization

____ other reasons (please explain) _____

Please identify Group Health Plan(s) and provide name(s) of Policyholder(s), carrier(s) and policy number(s):
Policyholder Name:_____
Carrier: _____
Policy Number: _____

Policyholder Name:_____
Carrier: _____
Policy Number: _____

If you are declining enrollment for yourself or your dependents (including your spouse) because of other Group Health Plan coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within [60 to 90] days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within [60 to 90] days after the marriage, birth, adoption, or placement for adoption.

I understand that if I later wish to enroll for any of the coverage(s) refused, I will be required to submit an Enrollment Form.

_____ _____

Signature of Employee Date

_____ _____

Signature of Witness Date