LANGARA COLLEGE

BENEFIT WAIVER FORM

I hereby **DECLINE** the following College paid benefit(s):
- ☐ Basic Medical (M.S.P.)
- ☐ Extended Health (Pacific Blue Cross)
- ☐ Dental (Pacific Blue Cross)

For the following reason:
- ☐ as I am covered under my spouse's plan
- ☐ as I am covered under another employer plan
- ☐ other: _____

For ***every benefit plan*** you waive, please complete the information below:

Carrier Number: _____ (MSP) _____ (Extended Health) _____ (Dental)

Group Number: _____ (MSP) _____ (Extended Health) _____ (Dental)

Spouse's SIN Number: _____
(If applicable)

EMPLOYEE'S NAME (Please print): _____

EMPLOYEE'S SIN: _____

EMPLOYEE'S SIGNATURE: _____