HMR
EMPLOYEE BENEFITS LTD.

Waiver of Group Benefits

A & W REGIONAL FRANCHISE ASSOCIATION

Employee's Surname	First Name	Middle Initial	Policy Contract Number	Social Insurance Number

Name of Employer	Date Employed YY MM DD	Birthdate YY MM DD

I hereby certify that I have been offered the benefits of my employer's group benefits plan under the above group number. The Benefits provided by this plan have been fully explained to me and:

I elect to waive the benefit(s) checked below due to similar coverage under my spouse's plan:

For myself and my dependents

- ☐ Extended Health
- ☐ Dental

For my dependents only

- ☐ Extended Health
- ☐ Dental

My Spouse is enrolled under: _____ *Group Number* _____ *Identity number* With _____ *Name of Insurance Company*

If my spouse's plan terminates, I must apply for coverage within 30 days of the date of such termination in order to be eligible for Dental and/or Extended Health Benefits under this plan.

_____ Date Signed

_____ Signature of Employee

Please TYPE or PRINT clearly in ink

Please complete and return by Fax or Mail to:

HMR EMPLOYEE BENEFITS LTD.
220-2186 Oak Bay Ave.
Victoria, BC
V8R 1G3
Tel: (250) 592-4614
Toll Free: 1-888-592-4614
Fax: (250) 592-4953