



# EXEMPTION REQUEST

## GROUP INSURANCE

- A- EXEMPTION REQUEST
- B- REQUEST TO PARTICIPATE

GROUP	DIVISION	CLASS
NAME AND GIVEN NAME OF EMPLOYEE		CERTIFICATE

**SIMILAR PLAN**  **SPOUSE**  **OTHER, SPECIFY** \_\_\_\_\_

NAME AND GIVEN NAME OF SPOUSE		
EMPLOYER'S NAME		
INSURER'S NAME	CONTRACT NUMBER	CERTIFICATE NUMBER

### A- EXEMPTION REQUEST

I declare the following :

- I was offered the group insurance benefits my employer subscribed for with **UL MUTUAL (The Union Life Mutual Assurance Company)**.
- The benefits of this plan were explained to me in detail. Being presently insured by another group insurance plan with similar benefits, I renounce to the following benefits:

ADHERENT AND DEPENDANTS

medical insurance       dental insurance

- I understand that to be admissible to this insurance plan hereafter, I must justify to the insurer's satisfaction that it is impossible for me to continue being insured under my present insurance plan.

ATTACHED IS A COPY OF THE INSURANCE ATTESTATION I AM PRESENTLY INSURED WITH. I CERTIFY THAT THE INFORMATION GIVEN IS TRUE AND COMPLETE.

**X**
**X**

DATE	EMPLOYEE'S SIGNATURE	ADMINISTRATOR'S SIGNATURE
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### B- REQUEST TO PARTICIPATE

- Date it became impossible to continue being insured under my present plan \_\_\_\_\_ Day | \_\_\_\_\_ month | \_\_\_\_\_ year
- Reason the insurance plan terminated \_\_\_\_\_
- Request to participate since I am no longer insured under a similar group insurance plan.

ATTACHED IS PROOF INDICATING THAT IT HAS BECOME IMPOSSIBLE TO CONTINUE BEING INSURED. I CERTIFY THAT THE INFORMATION GIVEN IS TRUE AND COMPLETE.

**X**
**X**

DATE	EMPLOYEE'S SIGNATURE	ADMINISTRATOR'S SIGNATURE
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