Total Health Care USA, Inc.
Employee Waiver Form

SEND CORRESPONDENCE TO:
EMAIL: marketing@THCmi.com
FAX: (313) 871-2860

This form is to be used for declining medical coverage with Total Health Care USA, Inc. only. If you wish to decline other coverage(s), you will need to check with your Human Resource Department.

I waive the right to enroll with Total Health Care USA, Inc. as offered to me by my employer for the following reason:
(please check one)

- ❑ I have other coverage offered by my employer.
- ❑ I have other coverage through my spouse or other family member.
- ❑ I have other coverage through Medicare or a pension plan.
- ❑ I have individual coverage through another source that is not employer-sponsored or employer-paid.
- ❑ I have no other coverage but choose freely not to enroll in my employer's plan.

I understand that I will not be eligible for coverage through Total Health Care USA, Inc. until my employer's next Open Enrollment period unless I qualify for coverage due to a HIPAA qualifying event (such as — marriage, birth of a child, adoption, or loss of other coverage).

_____
Employee Name Printed — Date

_____
Employee Signature — Date

_____
Employer Signature — Date

_____
Group Name — Group Number