



WAIVERS FORM

BASIC LIFE INSURANCE WAIVER

I hereby certify that I have been given the opportunity to enroll in life insurance offered by the Commonwealth of Massachusetts. I further understand that if I wish to enroll in the life insurance program at a later date, my acceptance into the program is contingent upon providing proof of good health.

Print Name

Signature

Social Security Number

Date

DENTAL INSURANCE WAIVER

I hereby certify that I have been given the opportunity to enroll in dental insurance offered by the University of Massachusetts Medical School. I further understand that if I wish to enroll in the dental insurance program at a later date, I must wait until the annual enrollment period.

Print Name

Signature

Social Security Number

Date

LONG TERM DISABILITY INSURANCE WAIVER

I hereby certify that I have been given the opportunity to enroll in group long-term disability coverage from Unum, a state sponsored disability insurance. I understand fully the benefits available to me under the plan. I decline to participate and hereby waive all benefits of the plan. I further understand that if I wish to enroll in the life insurance program at a later date, my acceptance into the program is contingent upon providing proof of good health.

Print Name

Signature

Social Security Number

Date

**Complete form, sign and Scan and E-mail to: Benefits.UMMS@umassmed.edu
or Fax to Benefits at 508-856-4049.**