Supplemental Health Care℠
STAFFING SPECIALISTS

2005 SHERIDAN DRIVE • BUFFALO • NEW YORK • 14223 • WWW.TRAVELNURSES.COM
TOLL FREE: 800-543-9399 • LOCAL: 716-873-5111 • TOLL FREE FAX: 1-800-868-0184 • FAX: 716-873-5573

Benefits Waiver

I, _____, understand that I am eligible to apply for health coverage through Supplemental Health Care and have declined the following coverage:

☐ Medical
for ☐Myself ☐My Dependents Only ☐My Spouse

☐ Dental
for ☐Myself ☐My Dependents Only ☐My Spouse

☐ _____
for ☐Myself ☐My Dependents Only ☐My Spouse

I am also declining participation in the following:
☐ 401K Plan
☐ _____

I understand in declining any of the above benefits at this time, I acknowledge if I change my mind I will be eligible only during open enrollment.

_____ _____
Employee Signature Date