Health Benefit in Lieu Payment – Optional

I, _____, will accept in lieu payment for all Health Insurance Benefits. I will provide proof of coverage within 30 days of hire. Please fill the table below to include information about your coverage.

	Policy No. 1	Policy No. 2	Policy No. 3
Type of Healthcare Coverage (check all that apply)	☐ Medical ☐ Dental ☐ Vision ☐ Other	☐ Medical ☐ Dental ☐ Vision ☐ Other	☐ Medical ☐ Dental ☐ Vision ☐ Other
Name of Insured Person			
SSN of Insured Person			
Name(s) of Dependent(s) covered under this insurance			
Insured's Relationship to Dependent(s)			
Name of Insured Person's Employer			
Name of Insurance Company			
Street Address or PO Box City State, Zip Code			
Insurance Company Phone No.			
Group or Policy Number			
Effective Date of Coverage			

_____ _____

Employee Signature Date Supervisor Signature Date